State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 29, 2005 Pauline Walbert P Insogna April 1918 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 04/20/1919 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 210 F Yrs. 217-10-4323 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28e-f show the Medical Examiner next be notified at MD **Allegany** Cumberland 1X Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 519 Pearre Avenue 21502 items 23a USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 0 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Clerk rmit. Pages 1 and 2 should be filed v spartment of Health and Mental Hygie portent: If item 27 is marked other t y injury or other treumatic event, IL. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Insogna Frances Cinelli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Timothy Walbert 13810 Briarwood Drive, LaVale, Maryland 21502 /son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Importent: If any injury or \* 4 Donation MD Vet. Cem. @ Rocky Gap 05/03/2005 Flintstone, Maryland 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 11\_weeks Head Trauma with Medical Complications /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Be Completed by Physiclan/Medical Examiner Due to (or as a consequence of): Hospitel or Attending Physicien; The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. ician use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy jo Month Day 4 Pregnant at time of death 5 Other (specify) should be detached Records, P.O. 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has director, page 2 autopsy performed? 1⊟ Yes 2又 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 Tes 2 X No Patient fell on walkway 02/10/2005 within 24 hours after death. To the Funerel Director; A 6:50 2 X Accident 3 ☐ Suicide investigation the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Friend's Residence 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 709 Lincoln St., Cumberland, MD 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D09157 April 30, 2005 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nRS 24 West Third Street, Cumberland, Maryland 21502 Paul Snow, M.D. 31. Date filed (Month, Pay 32. egistrar's Signature 02 State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	irtment of H tificate of L	ealth an D <i>eath</i>	d Mental I	Hygiene Reg. No	000	16502
		-2	Decedent's Name (First, Middle, Las.	t)		· · · · · · · · · · · · · · · · · · ·		2. Date o	f Death		3. Time of Death
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	and *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
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	28a-	rect	10e. Street and Number	Б	artimo	10f. Zip Code			10g. Cit	izen of What Co	ountry?
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	ma 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. V	Was Decedent of Hi	spanic Origin	? (Specify Yes o	r No-	14. Race - Ame	
21215-0036	be filed within 72 hours after death with the Maryland tat Hygiene. id other than "neturel", or itema 23a or 28a-f ahow avent. I're Madical Evarified mailied at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		f Yes, specify Cuba I ☐ Yes 21 No	Specify:	deno Rican, etc	.)	Black, White	White
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οu	Pages nent of h ant: If Ite		1 Burial 2 Cremation 3			natory or other plac rk Cemete		5/13/05			Maryland
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	01		30. Name and address of person who	completed cause of death (Item	п 23а) (Туре,				1	7 0	2003
1	0,		Kristine Dettlo			Avenue	Bal	timore,	MAI	YIAnd	21228
9 130	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 7	32. Registrar's Signa		Cont.					

AVARA, NANCY

Registrar

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	death ms 2	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S.	13. Was De	cedent of H	ispanic Ori	gin? (Spe	cify Yes or No-			ican Indian,
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	To the P within 24 To the F complete	Medi	one)	and manner	stated.		29c. Licenso				29d. Date sign		. Day, Year)
	vit To con		29b. Signature and title of certifier	Aren	110	-	/ Licensi	20	11	-	.9d. Date sid	11	In E
	$\cap$		30. Name and address of person wi		f death (Item 23a) (7	Kina Phine)		10/	5,		11/	104	
	7		John Paul	MA .	43/1/1/	1100	Van	NA	1	The	481	W.	2/2/10
	Sta		31. Date filed (Month Day, Year)	2. Regi	strar's Signature	SOF W	y y w		-V	1-01	1)1		7 -10
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 300 PM Month 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10225 Kensington Pkwy. #302 Kensington Montgomery 8. Date of Birth (Month, Day, Year)
Feb. 22,1912 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 ☐ F 93 052-05-8731 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Maryland TXXYes 2 ☐ No Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10225 Kensington Pkwy. #302 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify: 3√Vidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Milinary 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louis Eisenberg Fannie Gruber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Yoffee / Daughter 9921 Capitol View Ave., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) King David Cemetery 5/15/2005 Falls Church, VA 22. Name and Address of Facility
Rapp Funeral and Cremation Services 21. Signature of Funeral Service M06382 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD 20910 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WECK neumonia Due to (or as a consequence of) vascular acadent Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? 20 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → Mo 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 🗀 Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

The law requires that the death certificate be executed burial-transi attending physician as the esn. ö detached the þ signed Division of Vital Records, 99 should has page 2 certificate completely filled in by the funeral director, this s after death. or Attending To the Hospital within 24 hours a

Physician

/Medical

**Examiner** 

Director

Completed by Funeral

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Show

item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Madical Examinar must be notified at

al Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental Hisant: If Item 27 is marked out

permit. Pages:
Department of the
Important: if ite
any injury or ot

**Physician** 

/Medical

Examiner

filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAY 1 7 2005

29b. Signature and title of certifier



Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

29c. License number

H 0054337

29d. Date signed (Month, Day, Year)

Woodbine md

ORIGINAL

DHMH 17 Rev 1/2001

			State of Maryland / Dep. State Registrar  State Ce	artment of Health and M rtificate of Death	lental Hygie	4000	16507
	0.		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		MARTHA ELIZABETH BURTON		May 14,	2005	9:20 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
		Н	BROADMEAD  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)	Cockeysville  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Baltimore	
н	Funeral Director		1  M 2	Months Days Hours Min.	(Month, Day, Ye		place (State or Foreign Intry)
			Usual Residence of Decedent		Dec 14,		
	ahow		10a. State 10b. County 10c. City, Town or L. Maryland Baltimore County	cockeysville			10d. Inside City Limits
	Ba-f s	ecto			10-	Citizen of What Cou	1 ☐ Yes 2 No
	with t	Dir	13801 York Road	10f. Zip Code 21 03 0	109.	USA	mayr
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Mazical Examination collised at	Funeral Director		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - Amer	
ဖ	or Iter	Fur	Armed Forces?  1 Never Married 2 Married I Yes, 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White	, etc.
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Maryland 21215-0036	2 sho			ing Address (Street and Number or Rur		90010 10000	ALC: AND THE POST OF THE POST
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JO.	ages nt of h h: If ite		1 — Buriai 2 ACTEMATION 3 — Hemoval from State	matory or other place)	1000	2000	
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			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	6500 York, Rolling B	Transfer arrest,	Maryland	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
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rds	w requires been sign should be	ed t			1 🗆 Yes	2 <b>12</b> No 3 □ Pro	bably 4 Unknown
of Vital Record	S S S	Completed			24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
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ion	Attending Phyrdeath.  r death. ector: After thi	ation	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Ö	spital or At ours after o neral Direct filled in by						
	5 th 19	edical	29a. Certifier  (Check only one)  (Check only one)  (Check only one)  (Check only one)	ith occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fun completely	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month	Day, Year)
	- × - 5		Bankonna Canall Ma	D38392	_	5/15/	25
	6,9		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	211>	1.010	111.11.11
_	`		BARBARA CARROLL, M.19	1. 13801 YOF	KK KD.,	COCKE	VS VILLE, MI
. 44	Sta Regist		31. Date filed (MorKI AV. Year) 2005 Registrar's Signature				

05-3271 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene State Unpend Item 23a, 27, 28a-f per me C844 6-21-05 tas

Certificate of Death

Reg. No. KESHEON BALL 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2005 MAY **Physician** 11, 0547 Ам Kesheon Dante Ball /Medical 4b. City, Town, or Location of Death BALTIMORE CITY 4a. Facility Name (If not institution, give street and number)
JOHNS HOPKINS HOSPITAL 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12-30-2004 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 11 1X M 2□ F Hours Min Yrs. 217-71-5611 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f show the Modical Examinar must be notified at 1X Yes 2 No NA Baltimore MD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 448 E. 22nd Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1X Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify ð 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) NA College (1-4or 5+) NA NA ith and Mental Hygie 27 is marked other if treumatic event, ill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fil ment of Health and Mental H ant: If Item 27 Is marked otl Samuel Trayham Keyona Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 448 E. 22nd Street Baltimore, MD 21218 Keyona Ball/ Mother injury or other 20a. Method of Disposition
1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Western Cemetery 05-17-05 Baltimore, MD 21 Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failed a. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sudden Unexplained Death In Infancy /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner ng physicien and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) detached 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 \sum No certificate has 1 Yes 2 No Hospitel or Attending Phyelclan: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No Certification: To 28a. Date of Injury Found (Morth, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of unk Found 1 Natural 5 Pending after death. Diractor: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 5-11-05 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 448 E. 22nd Street Baltimore, Maryland 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Found At Residence 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 12, 2005 OCME

State Registrar

DHMH 17 Rev 1/2001

LING 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1111 Penn Street

mid

Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Day Year **Physician** 6: 20 PM Edward Louis Bryl 9 2005 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Levindale Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Aug 17 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1931 **Funeral** 212 28 0325 73 Yrs. Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a, State 28e-f show iral", or items 23a or 28e-f shov Examiner must be routilled at 1 ☐ Yes 2X No Director Maryland Anne Arundel Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. 5713 Phillip Street 21225 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Iter 1 ☑Yes 2 □No If Yes, Give Korean Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 4 years Elementary/Secondary (0-12) Broker Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Ann Koreczka Joseph F. Bryl 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is any injury or other traisons. Mary Bryl / Wife 5713 Phillip Street Baltimore, Maryland 21225 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland MD State Veteran Cem. 5/13/2005 4 Donation 5 Other (Specify) Gonce Funeral Service, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 xnomerousers 232 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myo Conch **Physician** Sudden disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Extra Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed MINTOLL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No anema 1 Yes Chronic ObsTrui Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 2 No Hospital: 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 2 1 🗌 Yes 1 / Inpatient 2 ER/Outpatient 27. Mapner of Teat 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural Injury 5 Pending investigation 2 🗌 No 1 Tyes death. Hospitel or Attendi 24 hours after death. 9 Funerel Director: A Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide To the Hospitel within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and use to the date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 DOO 60 170 0) address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

Edware

ORIGINAL

2434 W. Belvedere Avenue

Baltimore, MD. 21215

erindale

32. Registrar's Signature

2005

			For State Registrar	State of Maryl		rtment of H tificate of L			giene ()	5 16510	0
	Physici		1. Decedent's Name (First, Middle, Last)  MARY F BLAT	R				2. Date of De Month	Day	Year 0330 A	
	/Medio Examin		4a. Facility Name (If not institution, give s JOHNS HOP KINS		I ECAL CENT	4b. City, Town, or BALTII	Location of De		4c. County		
	Funeral Director		213-28-2289	14 0/78 5	yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	Ain. 8. Date of Bir (Month, Date 6 / 2 3	y, Year)	9. Birthplace (State or Ford Country) Georgia	eign
	death with the Maryland ms 23a or 28a-f show r must be natified at	or.	Usual Residence of Decedent  10a. State 10b. County		:. City, Town or Lo					10d. Inside City Lin	
:	or 28a-i	Funeral Director	Md Baltimo	ore	Du	ndalk 10f. Zip Code			10g. Citizen of V	What Country?	
	eath w	erall	7910 St. Monica	a Drive 2. Was Decedent Ever	in U.S. 13 V	212:		(Specify Yes or No	US.	A ce - American Indian,	
920	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heath and Mental Hygiene.  Department of Heath and Mental Hygiene.  Branicatist if the 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, it a Manical Examinat must be notified at once.	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cuba	n, Mexican, Pu	<sup>9</sup> (Specify Yes or No Jerto Rican, etc.)	Blac Specify	ck, White, etc.	
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7	filed within Hygiene. Ither than "		8	0	S	ales La		Para Adinah		stein's	
	should be to ind Mental H imarked ott umatic ever	To Be	17. Father's Name (First, Middle, Last)  J. W. Cain				Mar	Name (First, Midqle Y Wilso	n		
	and 2 sh ealth and m 27 is m her traum		19a. Informant's Name/Relationship (Ty) Ramona Salamony			•		r Rural Route Numb )r Balt	•		
lore,	Pages 1 an nent of Hea int: if item iry or other		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ R	20 amoust from State	Ob. Place of Dispo- cemetery, cren		e)	Date	20c. Location -	- City or Town, State	_
Saltimore	permit. Pa Departmer Important any injury		'4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License					neral H		yn Park, Md A.	1.
0	9 Q E # 9		23a Part I Enter the disease or Wardin	cations that caused the	death Do not ant	201 Dune	dalk A	Ave. Bal	timore	Md. 21222 Approximate	2
	hysician /Medical		23a. Part1. Enter the disease, or simpli shock, or heart failure. List ship or Immediate Cause (Final disease or condition resulting in death)	Multi	LOSCUR	Pneu				Interval Between Onset and Death	1
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С. вох	the death y the atter	hysiclan/Me	in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{LNo} \) 9 \( \text{Unknown} \)	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregnancy Other (specify)				onth Day Year	
rds, r	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions cor	tributing to death but no	t resulting in the ur	nderlying cause givi	en in Part I.	23e. Did 1	_/	tribute to the cause of death	
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	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	ospital:		Dth		Death (Check only	one)		
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DIVISION	if or Attending Physician: after death. Director: After this certification by the funeral director.	catlo	1 ✓ atural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Yea		M 1 🗆	k? Yes 2 □ No	206	/C44 d & l b		
N	ital or Al irs after or rat Directled in by	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At nome, farm, str pecify)	eet, factory, office		City or To		ber or Rural Route Number,	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medical Examination	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, death mination and/or in	occurred at the tin vestigation, in my o	ne, date and pl pinion, death o	lace, and due to the occurred at the time,	cause(s) and ma date and place,	anner as stated. and due to the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier	- Norus	?	29c. Licenso		0		ed (Month, Day, Year)	
j	1		30. Name and address of person who co	moleted cause of death	(Item 23a) (Type		-00			12005	
	St	ate	SEEMA NOUL, 494 31. Date filed (Month, Day, Year) MAY 1 7 20	32. Segistrar's S	Signatura,	Att 16A	LIIMO	RE MO 2	1224		
	Regist		MAY 1 7 20	105 parsens	15. Pop						

# Makent-Enown as Barbara Brown Baltimore, Maryland 21215-0036

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
For	State of Maryland / Department of Health and Mental Hygiene 0 5
1 _ For State	Certificate of Death

		1	For State Registrar	State of Maryland	Certificate		Reg	6000	16511
	Physicis		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al -	BARBARA  4a. Facility Name (If not institution, give str	LOTTIE		Wn, or Location of Death	05	4c. County of Death	2.13 p ™
	Examin	C1		0 11	nore Ba	1tmore	ciny		N/A
	Funeral Director		5. Social Security Number 0 6. Sex 105-32-2493	7. Age (In yrs. las	t birthday) If Under 1 Months D	Year If Under 24 Hrs. Days Hours Min.	8. Date of Bilth (Month, Day, Y 06/07/194	(ear) 9. Birth Cou	place (State or Foreign ntry) NY
	ow II	- h	Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	Town or Location				10d. Inside City Limits
	a-f sh	ctor	MD BALTII	MORE	BALTIMORE				1 ☐ Yes 2 No
	h with the 23a or 28	al Dire	10e. Street and Number 8525 SNOWREATH RO	D/	10f. Zip Co	21208	10g	. Citizen of What Cou	USA
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tall tygiene. do they than "naturel", or terme 23a or 28a-f show other than "naturel", or terme 23a or 28a-f show event. I're Medical Exacilizat invat be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 X Married  3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:	13. Was Deceder If Yes, specify	at of Hispanic Origin? (Sp Cuban, Mexican, Puerto No <i>Specify:</i>	pecify Yes or No- Pican, etc.)	14. Race - Ameri Black, White Specify:	
2-0	"natur	Completed	15. Decedent's Educa (Specify only highest grade		16a. Decedent's Usual ( (Give kind of work life. DO NOT use	done during most of work	king 16	6b. Kind of Business/Ir	ndustry
121	within iene. r than	omp	Elementary/Secondary (0-12) 5+	College (1-4or 5+)	OWNER	7-01/1-0-07	PI	RE-SCHOOL	
pu	be filed wi tal Hygien d other th	BeC	17. Father's Name (First, Middle, Last)				ne (First, Middle, Ma	aiden Sumame)	LEWY
<u>ya</u>	2 should be and Mental le marked eumatic ev	70	GEORGE  19a. Informant's Name/Relationship (Typ)	JACOB Print	KLEIN	ESTHER Street and Number or Ru	ral Route Number (	City or Town State Zi	LEVY
Mai	and 2 sh ealth and n 27 le n			SBAND		REATH ROAD			
ore,	Her Her tem		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Re	20b. Plac	ce of Disposition (Name netery, crematory or other	er place)		c. Location - City or T	
Baltimore,	Pages tment of l tent: If it jury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	ВЕТН		L PARK 05/1		RANDALLST	
Bal	permit. Pages Department of Importent: If if eny Injury or once.		21. Signature of Funeral Service Licenses	Rml	8900 RE	ISTERSTOWN	ROAD - PI	N & BROS., KESVILLE,	MD 21208
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. cause on each line.	Do not enter the mode	of dying, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Intha cen		em or h	age		
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	** Op of		IF FEMALE:	c. If yes, outcome of pregnance	01/			22d Data of dali	1001
O. Box	at the death certi by the attending itached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Fetal of 4 Pregnant at time of dea	leath 3 Ectopic pres			23d. Date of deli Month	Day Year
ds, P.O.	juires that I n signed by Ild be deta	by	Part II. Other significant conditions conf	nbuting to death but not result	ting in the underlying cau	use given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
of Vital Records,	The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use	Completed					24a. Was an autopsy perform	ed? prior to death?	topsy findings available ompletion of cause of
/ital	Physicien: The this certificate hiral director, page	Be	25. Was case referred to medical examiner?	ospital:		Other	ath (Check only one		
of	Physic rthis c ral dir	1: To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury	R/Outpatient 3 DOA 28b. Time of 28	d ☐ Nursing F c. Injury at Work?	lome 5 ☐ Resider 28d. Describe how	nce 6 Other (Spec winjury occurred	ity)
ion	Attending death. ctor: After y the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division	or Atte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory,	office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospitel or Attending I within 24 hours effer death.  To the Funeral Director: Affer completely filled in by the funer	Medical C	29a. Certifier (Check only one)	ician: To the best of my know er: On the basis of examination and manner stated.	rledge, death occurred at on and/or investigation, i	t the time, date and place n my opinion, death occu	e, and due to the car urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	ro the within ?	Med	29b. Signature and title of cedifier	and marrier states.	29c.	License number	29	d. Date signed (Month	n, Day, Year)
	/		· ///		7	200563	56	5/15/0	5
-	1		30. Name and andressor person who co	ΛΛ.	23a) (Type, Print)	200563 Hospita	106 TO	Saltina .	70
	\ 	ate	31. Date filed (Month, Day, Year)	32 Aegistrar's Signat	- Joseph	, nospira	101	2 CHIMON	
	Regist		MAY 1 7 20	1) BROWN A					

05-03340 RKD

			1 - State Unpend Iter		Maryland 28a f	d/Depa er me Ce	artmen rtificate	t <u>&amp;f</u> ½ e <i>of L</i>	e <u>al</u> ja a Death	ind M	lental Hy	giene ()	05	16512
	Physici	an	1. Decedent's Name (First, Middle,	Last)		D	HOOHE	D.T.			2. Date of Dea	Day	Year	3. Time of Death
	/Medic	1	ILENE 4a. Facility Name (If not institution,	give street and numi	ber)	В	UCCHEI		Location of	of Death	MAY	·	005 y of Death	6:37 A. M
10	Examir	er	33 WOODHOLLOW CO		,				MILLS				IMORE	
200	Funeral Director		219-58-6339	3. Sex 7 1 □ M 2 □ F	7. Age (In yrs. Ia 43	as <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt Month, Day AUG • 24	,1961	9. Birth	place (State or Foreign intry) MD
()	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
	ith the Marylan or 28a-f show	ctor	MD BAL	TIMORE		OWIN	GS MI	LLS						1 □Yes 2 🕅 No
	or 28	Director	10e. Street and Number	·			10f. Zip	Code				10g. Citizen of	What Cou	
	eath v	eral	33 WOODHOLLOW (	COURT 12. Was Deced	lent Ever in LLS	12	Was Dagge	ont of His	2111		poits Von as No	14 80	an Amar	USA ican Indian,
936	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Meniat Hygiene. I then 27 is marked other then "neturel", or Items 23a or 28a-f show other traumatic event, It., Medical Evant without be Lotiffed.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	Armed Ford	ces? 2 XX No	ĺ	of Yes, special 1 ☐ Yes		Specify:	girir (Spi i, Puerto	ecify Yes or No- Rican, etc.)	Speci	ack, White	
5-0	72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usua	l Occupa	tion uring most	t of work	ina	16b. Kind of I	Business/Ir	
121	vithin ne. hen "	mple	Elementary/Secondary (0-12)	College (1-4	4or 5+)		kind of wor DO NOT us		21.11.g 11.00.			HOMENC	A D D A	DEL
9	filed v Hygie other t		17. Father's Name (First, Middle, La	ist)		KETA	IL SAI		18. Mothe	r's Name	(First, Middle,	WOMENS Maiden Suma		KEL
Maryland 21215-0036	1.2 should be filed within h and Mental Hygiene. 7 Is marked other then " Iraumatic svent, I'm Mer	To Be	AARON			KREW				ORA	,,,,			FRIEDLAND
lary	and N and N Is ma		19a. Informant's Name/Relationship								al Route Numbe			
	of Health of Hem 27 I		JEFF KREW / BRO	OTHER	20h PI	9713 ace of Dispo			JRT -		ICOTT C			
Baltimore,			1 X Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Spe		tate ce	metery, crei	natory or of	ther place	1		6/2005	20c. Location		
I	그 돈 만 글		21. Signature Funeral Service Lice		CH1						LEVINS			E, MD
Ö	Depa Impo		) lon		_									MD 21208
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, of heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. <b>Mixed</b>	ch line.	orphin					or respiratory are		xicat	Approximate Interval Between Onset and Death ION
8760,	sate be executed shysician and the burial-transit	Icai Examiner	Sequentially list conditions; if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequ									
P.O. Box 68	or Attending Physicien: The law requires that the death certificate title death.  Director: After this certificate has been signed by the attending phys in by the tuneral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 940 Unknown		th 2 Tetal nt at time of de	death 3□	Ectopic pre						ate of deliv	ery Day Year
	w requires that been signed I should be det	by	Part II. Other significant conditions	s contributing to dea	th but not resul	lting in the u	nderlying ca	tuse give	n in Part I.			bacco use cor es 2 □ No	tribute to t	the cause of death?
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Vita	ysicien: iis certifica director,	o Be	25. Was case referred to medical examiner?  Yes 2 No	Hospital:							Check on or			COPNE
of	ding Phy I. After this funeral d	$\vdash$	27. Manner of Death	28a. Date of	Injury	P/Outpatien 28b. Time of		Bc. Injury Work			ne 5 🗆 Resid 28d. Describe h			%SCENE unk
ion	ending lath. oath. or: After he funer	atlo	1 □ Natural 5 □ Pending 2 □ Accident investigat	T CHIPM	-	:16 <sup>jury</sup>	a <sup>M</sup>		es 2 🏋	No				
Division	or Attenation after deat Director:	ertification;	3 ☐ Suicide 6 <b>X</b> Could no 4 ☐ Homicide determine	building	of Injury - At hor g, etc. (Specify)	ne, tarm, str	eet, factory	office		-	City or Tow	n, State) 33	Wood	Hollow Ct.
10	pital ours a lerel [	O	29a. Certifier 1 Certifying	found Physician: To the b	at hom		2 consumed a	at the time	doto on		wings M	ilis, r	aryı	and
otio	n 24 h	edical		aminer: On the bas and manne	is of examinati	on and/or in	vestigation,	in my opi	nion, deat	h occurr	ed at the time, o	late and place,	and due t	o the cause(s)
Cer	S E duco	Σ	29b. Signature and title of certifier				29c	License			2	29d. Date signe	ed (Month,	Day, Year)
	100		Jasher 1	Treeshe	es M	0		OCMI	4		MA	AY 15,	2005	
	# 3		30. Name and address of person what a series of the series	CELIDEA	9	-		Penr	n Str	eet	Reltim	one, Me	myla	nd 21201
	Sta Registr			2005	gistlar's Signatu	K Ap	als							

			1 - For State Registrar	State of Ma	-	artment of H			Reg. No.	15	16513
	Physici /Medio		Decedent's Name (First, Middle, Las	max	Coat	25		2. Date of De. Month	Day	Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give Howard Country	General		Col	Location of Death			ward	
	Funeral Director		5. Social Security Number 6. Security Number 271-10-4646	X 7. Age	(In yrs. last birthday) 98 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Nov • 30	y, Year) 0,1906	9. Birthpla Count Ohi	ace (State or Foreign ry) _O
	Maryland Ited at	tor	10a. State 10b. County Maryland Howard	.	10c. City, Town or Le	cation Columb	oia			10	d. Inside City Limits 1 XYes 2 □ No
	h with the 23a or 28e	Funeral Director	10e. Street and Number 6500 Freetown Rd.			10f. Zip Code	21044		10g. Citizen of V United		•
920	72 hours after death with the Maryland natural', or Itema 23s or 28s-1 show dical Examiner must be notified at	۾	11. Marital Status  1 Never Married 2 Married  3 Norced	12. Was Decedent Ev Armed Forces? 1 Yes 2000 If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H ff Yes, specify Cuba 1 ☐ Yes 2000No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Race Blace Specify	e - America ck, White, e	
21215-0036	c * 3	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12) 12		(Give	dent's Usual Occup kind of work done DO NOT use retired Foreman	during most of worki 1)	ing	Genera Wire W	1 Ele	•
Maryland	should be filed within and Mental Hygiene.  a marked other than umatic event, Ire M	To Be C	17. Father's Name (First, Middle, Last) Harold	Coates			18. Mother's Name Nellie	e (First, Middle,	Maiden Sumam Walker	18)	
	lith ar 27 is r trau		19a. Informant's Name/Relationship (7 Gary M. Coates /		1		and Number or Rura phia Mill				Code) 21036
Baltimore,	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 □ Burial 2 □ X remation 3 □ 1 □ Donation 5 □ Other (Specify		20b. Place of Disponentery, cre Chesapea		cory 5/14	Date 4/2005	20c. Location - Belts		
Balti	permit. Pages Department of h Important: if ite any injury or of		21. Signature of Funeral Service Licen	Moc	382   2	2. Name and Addre	ss of Facility al and Cr	remation	n Servic		
	Physician (Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Finaf disease or condition resulting in death)	aA CUL	he death. Do not en	ter the mode of dyin	g, such as cardiac c	or respiratory ar	rest,		Approximate Interval Between Onset and Death 3 day 5
8760,	Medical Examine phasician and phasician and phasician and the prinal-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):  consequence of):  consequence of):	artery	d infa disa	ease			15 years
Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the butial-transit	Physiclan/Medical	IF FEMALE: N/A 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetaf death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat	e of deliver	y Day Year
ds, P.O.	uires that t n signed by td be deta	by	Part II. Other significant conditions of				en in Part I.	23e. Did to	<b>V</b>	ribute to the	cause of death?
Vital Records,	The ate h page	Completed	1 (erebra	heart L vascu	ilar ae	cidents		24a. Was autop perfo 1 \( \text{Yes}	rmed?	rior to com leath?	sy findings available pletion of cause of
f Vita	ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1XInpatient	t 2 ER/Outpatie	nt 3□ DOA Oth	26. Place of Deather: 4 ☐ Nursing Ho		n <i>e)</i> dence 6 □Oth	er (Specify)	
ion of	Jing After fune	tlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day		Wor	y at k? Yes 2 □ No	28d. Describe l	now infury occurr	ed	
Division	al or Attendii s after death. I Director: A id in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (5 City or Tov	Street and Numb vn, State)	er or Rural	Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier Certifying Phyone) Certifying Phyone	vsician: To the best of iner: On the basis of e	wamination and/or in		-tains danah annus	and as she sime	dete and place a	and deep to t	the course/-1
)	To the within To the comp	M	29b. Signature and title of certifier	1~	m.D.	29c. Licens	565 3	1	29d. Date signed	08, 2	ay, Year)
65	12		30. Name and address of person who contains than ry Li,	om ause of dea	ath (Item 23a) (Type,	Print) idge R	d, col	um 50	a , 11	nD 8	21044
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 20	32 Registrar	M.D.  ath (Item 23a) (Type,  Kory R.  's Signature	W)					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** annor /Medical 4d. County of Death 4a. Fecility Name (If not institution, give street and number) Town, or Location of Death **Examiner** If Under 24 Hrs. Lon 10 7. Age (In yrs. last birthday)
Yrs. 8. Date of Birth Month, Day, Birthplace (State or Foreign
 Country) If Under 1 Year 5. Social Security Number Funerai Days Hours Min 1 □ M 2 X F 218-42-6465 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 □ No Director Nary and timore 10f. Zip Code 10g. Citizen of What Country? on Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, ILe M. Elementary/Secondary (0-12) College (1-4or 5+) ommer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) oleman 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. 4317 Ro 20b. Place of Disposition (Name of Rober ton Ave. 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Son Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servide Licensee 22. Name and Address of Facility Joseph L. Rus 2222 W. North neral Home Ave. Balto, Md. 21216 W.North 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breas+ Physician 3 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2X No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 I ER/Outpatient 3 I DOA Other: 4 Nursing Home 1 🗌 Yes 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attanding Is within 24 hours after death.
To the Funeral Director: After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) 29c. License number Mary (and 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier amson h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANCY MD AWSON Greene 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

		-	For Stata Registrar	State of	f Marylan		artmen tificate				1ental H	lygie Reg.	/ UI	)5	651	5
ı	Physicia	an	1. Decedent's Name (First, Middle, L		an						2. Date of Month May	_	Day 0	2005	3. Time of D	
	/Medic		Thomasine L  4a. Facility Name (If not institution, g.				4b. City,	Town, or I	Location (	of Death	Titay			y of Death	0.00	
	Examin	ęr	Mariner of Beth		,		Bet	hesd	la				Mor	ntgome	ery	
	Funeral			Sex	7. Age (In yrs.	**	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month,	Birth Day, Ye	ear)	9. Birthp	place (State or	Foreign
	Director		578-54-8128	1 M 2 F	64	Yrs.	Wioridia	Days	110013	141111.	March	16	1941	Washi	ngton,	D.C.
	pur *	1	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	0d. Inside City	Limits
	Maryis 1 sho	JO.	D.C.		T	Washing	gton								14 Yes	2 □ No
	the P	rect	10e. Street and Number				10f. Zip	Code				10g.	Citizen of	What Cour	ntry?	
	h with	Funeral Director	1436 R Street #4	03			200	009					US	SA		
	ems S	ner	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	.S. 13. V	Was Deced	ent of His	spanic Or n, Mexicar	igin? (Sp	ecify Yes or Rican, etc.)	No-		ce - Americack, White,		
0	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	2 <b>¼</b> No ∕e		1 ☐ Yes		Specify:				Speci	ity: Bla	ck	
212-003p	hours tural		3 Widowed 4 Divorced  15. Decedent's	Year or Da	ates:	16a, Deced	dent's Usua	I Occupa	tion			16	h Kind of I	Business/In	dustry	
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yiand	Menta Menta arked	To	Joshua A. Jorda	an							Vine					
Zaz	2 sho		19a. Informant's Name/Relationship								al Route Nui					
a) =	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23s or 28s-f show importent: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event. It is Medical Examination in the incilled at ance.	13	Michael Jordan/So	on	20b. i	Place of Dispo	sition (Nan	na of		03 W	ashing Date	ton	D.C.	- 200 - City or Te	own, State	
وَ	ages nt of the :: If ite		1 ☐ Burial 2 X Cremation 3		State	cemetery, crer tropol:	natory or o	ther place	9)	5-23	3-05			dria,		
Baltimore,	artme orteni injury	ı	*4 □Donation 5 □ Other (Special Service Lice)		TIC			d Addres	s of Facili		shall	's l	Funer	al Ho	vA. ne	
e E	Departiment of the post of the		10 0 m	and la	100						Wash.					
	-		23a. Part1 Enter the disease, or co shock, or heart failure. List on	mplications that c	caused the dear	th. Do not ent	er the mod	e of dying	g, such as	cardiac	or respirator	y arrest	,		Approximate Interval Between	een
	Physician		Immediate Cause (Final disease or condition		schemic	Cardio	omvon	athv							Onset and De	eath
7	/Medical		resulting in death)	_ d	(or as a consec		1									
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	ed isit	Examiner	cause. Enter Underlying	Due to	(or as a consec	quence or):										
	xecut and	xan	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec	quence of):							-			
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9	tificat ng phy as th			3												
ROX	leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		⊒Ectopic pi	egnancy						ate of deliv		ear
		slcl	in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	4□ Pregr 9□ Unkn	nant at time of o	death 5	Other (sp	ecify)				_		Olidi	Day	241
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Ě	The law cate has page 2.	ф									Pi	utopsy erforme	d? ] No	prior to co death? 1 \( \text{Yes}		use of
Vital		0	25. Was case referred to medical			-			26. Plac	e of Dea	1 ☐ Ye		7 140	1 1 163	20140	
Ξ	nysich nis cer direct	To B	examiner? 1 ☐ Yes 2 ②XNo	Hospital: 1 🗆	Inpatient 2	] ER/Outpatier	nt 3 🗆 DC	OA Cthe	er: 4 <b>%</b> N	ursing H	ome 5 R	esidend	ce 6 🗆 O	ther (Speci	fy)	
n of	ding Ph h. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date (Mon	of Injury oth, Day Year)	28b. Time o Injury		8c. Injury Work			28d. Descri	be how	injury occi	urred		
Sio	vttendi death. ctor: A y the fu	catl	2 Accident investigat	ho		town town to	M		Yes 2	No	29f Locatio	n (Stra	ot and Nuc	nhar or Rur	al Route Numb	ar
Division	or At after of Direct in by	Certification:	4 Homicide determine	200. Flace	e of Injury - At h ing, etc. <i>(Speci</i>		reet, tactor	/, опісе			City or	Town,	State)	nber of ridi	ar rioule ruini	G1,
	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 X Cartifying	Physician: To the	e best of my kn	owledge, deat	h occurred	at the tim	ne, date a	nd place	, and due to	the cau	se(s) and r	manner as s	stated.	
	n 24 h n 24 h ne Fu bletely	edical	(Check only 2 Madical Ex	aminar: On the b and man	pasis of examin nner stated.	ation and/or in	vestigation	, in my op	oinion, de	ath occu	rred at the tir	ne, date	and place	e, and due t	o the cause(s)	
	To th To th comp	Me	29b. Signature and title of certifier	0		16.6 2	29	c. License	number			29d	Date sign	- 1	Day, Year)	
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	Dhusisi		1. Decedent's Name (First, Middle, L	.ast)							2. Date of Dea	ath Day	Year	3. Time of Death	
	Physicia /Medic		James E	dward Cro	ok						May 8,	2005		5:47 A <sup>N</sup>	Λ
	Examin	er	4a. Facility Name (If not institution, g				4b. City, Tow	n, or L	Location o	f Death		4c. 0	County of Deat	h	
		3	Anne Arundel (				Anna If Under 1 Ye		is If Under:	74 Hen			ne Aru		
	Funeral		5. Social Security Number 6. 577–52–8546	Sex 7. A 1 ★ M 2 ☐ F		last birthday) Yrs.		ys	Hours	Min.	8. Date of Birt (Month, Da	y, Year)	Co	hplace (State or Foreig	
	Director		Usual Residence of Decedent		66						Feb 17	, 193	39   was	shington DC	_
	Mot III		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits	s
	Mar Perst	ţo	MD Anne	Arundel		Chur	chton							1 🛣 Yes 2 🗌 No	0
	or 28	Director	10e. Street and Number		_		10f. Zip Cod	ie				10g. Citiz	en of What Co	untry?	
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	tems	Funeral	11. Marital Status	12. Was Deceden Armed Forces	3?	.S. 13.	Was Decedent If Yes, specify (	of Hisp Suban	panic Orig	gin? (Spe , Puerto	city Yes or No Rican, etc.)	- 1	<ol> <li>Race - Ame Black, White</li> </ol>		
36	within 72 hours after death with the Marylend ene. then "natural", or items 23s or 28e-f show the Wedital Examiner must be motified at	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give			1 Yes 2 🔀	No	Specify:				Specify: V	White	
21215-0036	hour fural	pa pa	15. Decedent's	Year or Dates	S:	16a Dece	dent's Usual Oc	cupat	ion			16h Kin	nd of Business/	Industry	
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פַ	e filec othe vent,	BeC	17. Father's Name (First, Middle, La	st)		•		1	18. Mothe	r's Name	(First, Middle,	Maiden S	Sumame)		_
<u>la</u>	uld by Menta rrked	To E	John Cro	ook					Ι	da R	oberts				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.	1	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Str	eet ar	nd Numbe	r or Rura	al Route Numbe	er, City or	Town, State, 2	Zip Code)	
≥,	and ealth m 27 ner tr		Tracy Guntow		1				s Mil		ad Brid				
Baltimore,	Jes 1 I of H If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Stat		emetery cre	osition (Name o matory or other	nianai	,	_	Date 5 / 2005		cation - City or		
Ē	ment tent:		'4 ☐ Donation 5 ☐ Other (Spec	cify)	Fo	rt Lin	coln Cr	ema	atory	_ 	3/2003		twood,		
3a	permit Depar Impor Impor any in		21. Signature of Funeral Service Lic								Lincol				
	40360		Musclin T. K.  23a. Part1. Enter the disease, or co		ad the deet						ad Bren		od MD 20	Approximate	
8760,	/Medical Examiner bulkisician end the brital-transit the brital-transi	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a		uence of):	the	//10	nei	ny (	m K	Y P	he	Onset and Death	
.O. Box 68	death certifi e attending od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta at time of d	death 3	⊒Ectopic pregni ∃ Other (specif)					23	3d. Date of del Month	ivery Day Year	
S, D	The law requires that the de tte has been signed by the a page 2 should be detached f	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying cause	giver	n in Part I.			obacco us Yes 2 🗆	_	the cause of death?	n
Vital Record	The law requ	Completed	<u> </u>								24a. Was autop perfo 1 Yes		24b. Were au prior to death?	topsy findings available completion of cause of	0
/ita	nding Physiclen: Th th. : After this certificate funeral director, pag	Be (	25. Was case referred to medical examiner?							of Death	(Check only o	ne)			_
<u></u>	hysi this c	은	1 ☐ Yes No			ER/Outpatier		Other	4 🔲 140		me 5 Resid			cify)	
N C	ting F	ion:	27. Manner of Death Natural 5 Pending	28a. Date of In (Month, D	jury Day Year)	28b. Time o Injury		njury a	? _		28d. Describe	now injury	occurred		
Sic	Attending r death. ector: After by the fune	icat	2 Accident investigat 3 Suicide 6 Could not	be ass Blace of I	niunc. At h	ome farm et			es 2∐!		28f Location /	Street and	d Number or Ri	ural Route Number,	
Division of	l or Atten after deat Director: I in by the	Certification:	4 ☐ Homicide determine	building,	etc. (Specif	y)	eet, lactory, on	100			City or Tox	vn, State)	)	ara riodio reditibol,	
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)	Physician: To the bes aminer: On the basis and manners	of examina	owledge, deat tion and/or in	h occurred at the	e time	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and	and manner as place, and due	s stated. to the cause(s)	
	To the I within 2 To the I complet	Me	29b. Signature and inte of certifier	Scott Ab		MD			number	81			signed (Month		
5	7		30. N. me ddress of person who Scott Abereo	o completed cause of	_		Print)	st	- 12	06/	him	> 1	11) 7	1205	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 20	Regis	strar's Signa	ature Ana	all!	-)	- 4/	-1,	irricae	- 1 12			

OK per mes sparks

YVES CUBILLOS MORAGA Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene () 05-3188 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:42A M **Physician** H. Cubillos-Moraga 8. 2005 MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
UNIVERSITY HOSPITAL 4b. City, Town, or Location of Death **Examiner** BALTIMORE CITY Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
April 12,1985 Colorado 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 1⊠M 2□F 20 Director 234-37-3922 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show ral', or Itams 23e or 28e-f shov Examiner must be nutilised at 1 Yes 2X No Director Maryland Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5626 Rockbridge Court 21045 U.S.A. Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2□ No Baltimore, Maryland 21215-0036 Specify: Completed by Chiléan 3 ☐ Widowed 4 ☐ Divorced White "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ages 1 and 2 should be filed within 72 ho nt of Health and Mental Hygiene. : If itam 27 Is marked other then "natur or other treumatic avant, II.x M. JIC.II. 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pedro Oscar Cubillos-Herrera Ledda Moraga-Hope ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5626 Rockbridge Ct. Columbia, MD 21045 Pedro Cubillos-Herrera (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Pages 1 1 ☐ Burial 2 ACremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Chesapeake Crematory 05-14-2005 Beltsville, MD 5 Other (Specify) 4 Donation 21. Signature uneral Service Licensee Witzke Funeral Homes, Inc. M01290 5555 Twin Knolls Rd., Columbia, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Physician Inquires /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physiclan/Medical as the IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. | detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed? certificate has 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XYes 2 ☐ No 1 ☐ Inpatient 2☐ ER/Outpatient 3☐ DOA haral Diractor: After this c filled in by the funeral dire 2 28d. Describe how injury occurred driver of vehick 28b. Time of 28c. 28a. Date of Injury (M. nth., Day Year) 27. Manner of Death Certification: involved in a collision Injury 1 Natural 5 Pending 11:04 PM 18/05 1 Tes death. investigation 2 Accident 28e. r lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Old Stack history 21. 20 Meadown view 29 House of MD 6 ☐ Could not be ີ່ Suicide determined or A 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di road 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ZX Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature/and title of certifier OCME MAY 9, 2005

State Registrar

Yamela E. Soithaul, MD
31. Date filed (Month, Day, Year)

MAY 1 7 2005



30. Name and address of person who completed cause of death (Item 23a) (Type. Pint 1 Penn Street Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 tell 31 per dyr 2843 5-17-05 Vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MAY JOHN HENRY COX SR. 2330 PM **Physician** ĭö 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Moz 9. Birthplace (State or Foreign Hatfield Bethesda NIH enter | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 1 (Months Days | 9 4 4 7. Age (In yrs. last birthday) 5. Social Security Number 219-42-0798 Social Security Number **Funeral** PENNSYLVANIA **№** M 2 🗆 F 61 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No MD BALTIMORE WHITE HALL Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number death with 19700 GRAYSTONE ROAD 21161 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes X No Specify: Specify: WHITE 2 Baltimore, Maryland 21215-0036 ð 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) MECHANIC MECHANIC 12 permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other than injury or other traumatic event, the ODGE. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARION ROY COX AMERICA GERTRUDE HAWKES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19700 GRAYSTONE ROAD WHITE HALL, MD 21161 JOYCE GOLOBOSKI Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State CARROLL CREMATORY INC. MAY 16 2005 HAMPSTEAD, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility NENRY W. JENFINS + SONS CO 21. Signature of uneral Service Licensee ANCI Monkton, MD 71111 u 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (Bncer Priysician Luna Non-small cell /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine and Il-transit that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Box 68760 Physician/Medicai the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the atte 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Failure Rend Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes certificate or Attending Physician: 26. Place of Death Check only one 25. Was case referred to medical Be 1 Yes No Other: 4 \( \sum \) Nursing Home Hospital: 5 ☐ Residence 6 ☐ Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA ۵ this nours after death. nere! Director: After this / filled in by the funeral d 28d. Describe how injury occurred D te of Injury (Month, Day 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10,2005 MGA JOK, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 Bryan FISK F.
31. Date filed (Month, Dannay 1 7 2005 Registres Signature State

Registrar

LLI	AM COLI	E .	State of Man	land / Depa 27 per mg					ental Hyg	iene,	05	16519
	Physici		1. Decedent's Name (First, Middle, Last)  WILLIAM COLE		uncate	OI D	Call		2. Date of Deat Month MAY 1:	h Day	Year	3. Timo of Death 0112 A M
	/Medic Examin	er	4a, Facility Name (If not institution, give street and number) 1502 FREDERICK ROAD ROOM 10		4b. City, To	own, or L	ocation o	of Death		4c. Cour	nty of Death	
	Funeral Director		212-32-5929 1 <sup>™</sup> 2□F	n yrs. last birthday) 9 Yrs.	If Under 1 Months	Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 7-14-19	Year) 35	9. Birthp Coun MARYI	lace (State or Foreign ltry) LAND
)	Maryland f show	tor	Usual Residence of Decedent         10a. State         10b. County         10           MD •         BALTIMORE	Oc. City, Town or Lo							1	0d. Inside City Limits
	with the a or 28a. Lbe rectif	Director	10e. Street and Number 3702 PARKFIELD RD.	TIRESVI	10f. Zip C	ode 1208	2		10	og. Citizen o	of What Coun	ntry?
036	J within 72 hours after death with the Maryland jiene. Then "naturel", or Items 23a or 28a-f show Ite Mudical Examerational by radilled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Eve Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:			nt of His y Cuban	panic Orig , Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. R	ace - Americ lack, White,	
Maryland 21215-0036	d within liene. r then "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) - 6 0-		dent's Usual kind of work DO NOT use ENCY M				ng		Business/Ind	
land	should be filed of the state of Mental Hygie marked other imatic event, III	To Be C	17. Father's Name (First, Middle, Last) CHARLES COLE	(First, Middle, A		ame)						
	12 th arr		19a. Informant's Name/Relationship (Type, Print) ROSETTA DAVIS (NIECE)		I Route Number.							
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If Item 27 eny injury or other tro once.		1 🖫 Burial 2 ☐ Gremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cometery, creat MARYLAND 1	natory or oth NATION . Name and	er place) AL Address	5 of Facilit	-18- y PHI	2005 L	AUREL, UNERAI	HOME	LAND
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.O. Box 68	The law requires that the death certificat lie has been signed by the attending phy page 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic preg Other (spec					- 1	Date of delive	ery Day Year
<u>α</u>	ires that i signed by d be deta	by	Part II. Other significant conditions contributing to death but n									ne cause of death?
Vital Records,		e Completed	25. Was case referred to medical	•					24a. Was an autops perform	y ned? ! 🗆 No	b. Were auto prior to cor death? 1 Dayes	psy findings available mpletion of cause of 2 \( \) No
of Vii	Phys r this ral dii	To B	examiner? 1XX Yes 2 □ No  Hospital: 1 □ Inpatient  27. Manner of Death  28a. Date of Injury	2 ER/Outpatier		Other	. 4 □ Nu	rsing Ho	n <i>(Check only on</i> me 5 ☐ Reside 28d. Describe ho	nce <b>XX</b> C		at scene
Division	Hospitet or Attending I 4 hours after death. Funeral Director: After tely filled in by the funer	Certification;	1 ANatural 5 Pending (Month, Day Y investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury building, etc.	ear) Injury  - At home, farm, str	М		es 2 🗆	No	28f. Location (St. City or Town	reet and Nu		l Route Number,
	To the Hospitel or within 24 hours after To the Funeral Director Completely filled in b	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of real control of the basis of examiner: On the basis of examiner states	amination and/or in								
)	To the within 2: To the I complete	Me	29b. Signature and title of certifier  Jaskas Sheens	erg Mi	5	License (	number OCME			_	ned (Month, 2005	Day, Year)
		211	30. Name and address of person who completed cause of deat Tashu Z Greenberg M. D 31. Date filed (Month, Day, Year)	1	11 Per	n St	treet	: Ba	altimore	, Mary	land	21201
	Sta Registr		MAY 1 7 2005	Signature Space	the s							

				State of N	Maryland	-	artment o			nd M	lental H	ygiene Reg. No			65%	20
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DHMH 16 Rev 6/95

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 16b per the 943 5-17-05 vt. State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 05/15/2005 4:53 A William Anthony Dailey /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 X M 2 □ F Director 01/01/1928 MD 219-10-7417 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show tre Medical Examiner; and be notified at 1 ☐ Yes 2 No Directo Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 2712 Finch Road U.S.A. Funeral filed withIn 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 1946 – If Yes, Give Year or Dates: 1947 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify. þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 'Give kind of work done during most of working life. DO NOT use retired) Balto. City Pages 1 and 2 should be filed withIn nent of Health and Mental Hygiene. int: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) MD State Police Police Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frieda Louise Koellner William A. Dailey, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Matulaitus/Nephew 242 Oak Ridge Dr., York, PA 17402 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. Bayview Crematory 05/16/05 1 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, 21. Signature of Eureral Service Licensee 169 Riviera Drive, Pasadena, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 40 Co Chal /Medical Examiner Orter Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atter in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) O 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, sign sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 1 Yes 2 X No 1 Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М efter death Director: the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide ō To the Hospital o within 24 hours eff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MD 140 completed gause of death (Item 23a) (Type, Print) onth, Day, Yea State Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 1 per doc 9846 8-1-05 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Stone Dowdy Anne 2002 Physician 2133 May Stone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, wn, or Location of Death Examiner Johns Hockins Medical Bayview HIMOre 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–19–1926 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√3 F 78 042-20-7032 Yrs. **Director** Missouri Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Menial Hygiene.
ant: If item 27 is marked other then "natural", or Items 23s or 28e-f show ury or other treumatic event, if a Medical Examinar must be millihed at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes XXNo **Funeral Director** MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 79 Carona Court 20905 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black. Specify: Completed by 3 ☐ Widowed 4 ₺ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 4+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Summer Stone Madalene Chafin Stone ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is eny injury or other tree once. 79 Carona Court Silver Spring MD 20905 Jocelyn Dowdy (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Chesapeake Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 05-14-2005 Beltsville, MD 22. Name and Address of Facility
Rapp Funeral & Cremation Service
933 Gist Ave Silver Spring MD 20910 21. Signature of Funeral Service Lice M00387 Steple & Xohunan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FUNGAL SEPSIS /Medical Due to (or as a consequence of): Examiner PS EUDOMONAS PUEUM ONGA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine transit The law requires that the death certificate be executed OBSTRUCTIVE CHRONIC PULMONARY Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has le 2 page certificate 2 No 1 Yes Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 1 ☐ Yes 2 No 10 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident completely filled in by the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) after within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 (ANTONA RAKIS) MD AF 2664200-A382 MAY 7, 2005 who completed cause of death (Item 23a) (Type, rint)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month

gistrar's Signature

Eastern Ave., Baltimore, MD 21224

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year MAY 3:30 P M 15 4 CUS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8 7. Age (In/yrs. last birthday) 8. Date of Birth 9 Birthplace (State or Foreign Country) Habama 5. Social Security Number & Sex **Funeral** 1**∑**M 2□F 3123 Days 36 L Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Marylana ltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (\$No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturai", or 1 Yes 2 No Specify: Blac 3 ☐ Widowed 4 ☐ Divorced Be Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Unemploye permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked othe any injury or other traumatic event, ouce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Denni Name/Relationship (Type, Print) (Sister - In 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) enn Date 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2005 \*4 ☐ Donation 5 ☐ Other (Specify) downe, -10n 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph L. Russ Fu 2222 W. North Ave. 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** arrythemics Cardiac 15 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 4rs atheroscieratic heant disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and thed for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed 1548 Hypentensian Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Hailure rentilater dependent 1 Yes 2 No 3 Probably 4 Unknown Be Completed Chronie menal hemodialying 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed: 1 ☐ Yes 2 Ø No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 30494 5-16-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \_ 7 16 maid En choice Lant #302 Ballimore mo DESAI 31. Date filed (Month, Day, Year) MAY 1 7 2005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

CPM 05-03214 Rodney Davis

	-	For State	State of Maryla	•	artment of Hea rtificate of De			6000	16524
		Registrar  1. Decedent's Name (First, Middle, L	ast)		tinoate of be	Jairi	2. Date of De		3. Time of Death
Physicia /Medica	-	Rodney Davis				_	Month May	09, 200	
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Funeral Director		5. Social Security Number 6. 218-54-4420	5ex 7. Age (In yrs 1 ☐ 7 € 1	Yrs.		Hours Min.	(Month, Da		Birthplace (State or Foreign Country)
	-	Usual Residence of Decedent					Oct. 1	0 1931	
show		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 M No
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To the within 2 To the complet	Mec	29b. Signature and title of certifier	A A		29c. License n	umber		29d. Date signed (M	onth, Day, Year)
6		Du OI	2		OCME			May 09,	2005
7		30. Name and address of person wh	o completed cause of death (Ite	em 23a) (Type,					
0		ANA	RUBIO, MD	)	111 Penn S	treet E	Baltimo	re, Maryla	and 21201
Stat Registra	-	31. Date filed (Month, Day, Year)	2005 32 Registrar's Sign	nature	realls.				

			1 - For State Registrer	State of Marylan		artment of H			giene leg. No: 005	16525
	Dhusisi		Decedent's Name (First, Middle, Last	( )				2. Date of Dea		3. Time of Death
	Physici /Medic		ETHEL LYN	N DOUGH	IERT			May &	sixth 2005	
	Examin	er	4a. Facility Name (If not institution, give Saint Agnes	HOSPital		4b. City, Town, or Batter	r Location of Deal	n O	4c. County of Dea Bautin	
	Funeral Director		5. Social Security Number 6. Se 216-54-3087	x 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1 <sup>Yea</sup> 1948 9. Bir	thplace (State or Foreign ountry) Maryland
	יסי		Usual Residence of Decedent  10a. State 10b. County	100 Cin	. Tour or la	antin a				10d Inside City Limite
	Aaryla I shov	ō			nsvil.					10d. Inside City Limits
	28e-	rect	MD Baltimore  10e. Street and Number	Catt	J112 A T T	10f. Zip Code		1	10g. Citizen of What C	ountry?
	th with	al Di	32 North Prospect	Ave.		21	1228		USA	
036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-1 show any injury or other traumatic event, the Madical Exertification to once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2♣ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 P No	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify:	
20	72 ho	eted	15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usual Occup	ation during most of wo	orking	16b. Kind of Business	/Industry
21215-0036	iene. r than "	omple	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. I Homema	kind of work done DO NOT use retired ker	3)		Home	
Maryland 2	d be filac ental Hyg cad othe c event,	To Be C	17. Father's Name (First, Middle, Last) Melvin Hood					me (First, Middle, I		
ary	should be and Mental s markad c	-	19a. Informant's Name/Relationship (7)	/pe, Print)	19b. Mailir	ng Address (Street	and Number or A	ural Route Number	r, City or Town, State,	Zip Code)
	and 2 ealth a m 27 Is		Sam Dougherty -				spect Av		sville, MD	
Sore Bore	Pages 1 nant of H int: If iter iry or oth		20a. Method of Disposition  1 ③Burial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, crer	sition (Name of natory or other place herd Ceme	etery 5-	Date 12-05 F	20c. Location - City of Ellicott Ci	
Baltimore,	permit. Page Department Importent: If eny injury or once.		<ul> <li>4 □ Donation 5 □ Other (Specify,</li> <li>21. Signatur of Funeral Service Lights</li> </ul>			. Name and Addre			k Funeral	
Ba	Depa Depa Impo eny ir		him Ac	hlanau					re, MD 2122	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death ne cause on each line.	Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Anoxic	Enc	phalo,				Onset and Death
	Examiner			Due to (or as a consequence)	uence of):	Arres	t J			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	V	11/1 = 3	, C			
	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.						
8760,	icate be executed physician and the burial-transit	al E	rosaning in oodiny cast	Due to (or as a consequent	Teuce of):					
687		edical		d.						
Вох	th cert ending r use a	an/M	23b. was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy	,		23d. Date of de	
O. E.	The law requires that the death certifi ate has been signed by the attending cage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4☐ Pregnant at time of de 9☐ Unknown		Other (specify)			Month	Day Year
<u>α</u>	res that the ignad by be detacted		Part II. Other significant conditions co	ntributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
Vital Records,	v requires been sigr should be	ed by	Parkinson	n's Disec	rse			1 □ Y	es 2 No 3 P	robably 4 Unknown
eco	e law requ has been je 2 shouli	Completed						24a. Was a	sy prior to	utopsy findings available completion of cause of
<u>=</u>								perfor 1 ☐ Yes	med? death? 2 No 1 □ Ye	s 2 No
Z.	ysicien: is certific director,	o Be	25. Was case referred to medical examiner?	Hospital: 1 Minpatient 2 🗆	ER/Outpatier	nt 3□ DOA Oth	er	ath (Check only or	ne) lence 6 □Other (Spe	ocifu)
0 ر	ding Phys	in: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of				ow injury occurred	sony)
sior		catlo	Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2 □ No			_
Division	• Hospital or Attend 24 hours after death • Funerel Director: etely filled in by the	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str /)	eet, factory, office		28f. Location (S City or Town	itreet and Number or F m, State)	iural Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edical		rsicien: To the best of my kno iner: On the basis of examina and manner stated.						
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	NA a	n.	29c. Licens	e number	2	29d. Date signed (Mon	th, Day, Year)
-	110		Khairunnisa	n Masoc	$\alpha$	16	2750	)	Iviay 6,	2005
(	L"		30. Name and address of person who can have had	nes Hos	pita	Print) Bo	ultimo	re Mo	ryland	21229
	Sta Regist		31. Date filed (Month, Day, Year) WAY 1 7 2	32. Segistrar's Signa	thre	ande)			U	

DOUGHERTY, ETHEL

		-	For State Registrar	State o	of Maryland		rtment of H			giene	15	16526
			Decedent's Name (First, Middle,	Last)					2. Date of Dea	ith		3. Time of Death
	Physicia		Kathrin	E. Day	,				May	Day 2	Year 1005	13:58 M
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Dea			ty of Death	
	LXAIIIII	-1	6367 Cedar La	ine			Columbi	а		Но	ward	
_	Funeral		5. Social Security Number	S. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h /. Year)	9. Birthp	lace (State or Foreign
	Director		218-48-1048	1 □ M 2 🙀 F	93	Yrs.	Wichians Days	110013	May 8,	1912	Mary	
	pu *	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	. Town or Lo	cation				1	0d. Inside City Limits
	sho	5	Maryland Howa	and a		Columb						1 ☐ Yes 2 🖾 No
	28a-f	Directo	10e. Street and Number	itu		OTUILD	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	with a or		6367 Cedar Lar	10			210	44		U.S.		•
	filed within 72 hours after death with the Maryland Hygione. that than "natural", or Itams 23e or 28e-f show ant, the Medical Examinat must be multified at	Funerai	11. Marital Status	12. Was Dec	edent Ever in U.S	S. 13. \	Vas Decedent of Hi f Yes, specify Cuba		Specify Yes or No-		ace - Americ	
0	r Itan	F	1 Never Married 2 Marrie	Amed F	2X No				rto Rican, etc.)		ack, White,	etc.
Maryland 21215-0036	al', o	þ	3 X Widowed 4 ☐ Divorced	If Yes, G Year or D	ive Dates:		I□Yes 2⊠No	Specify:		Spec	Wh	ite
ည	72 ho	Completed	15. Decedent's (Specify only highest			(Give	lent's Usual Occupa	turina most of we	orking	16b. Kind of	Business/In	dustry
7	ithin	npi	Elementary/Secondary (0-12)	1	(1-4or 5+)		OO NOT use retired					
2	led w lygier har th	S	12			Sa	les Clerk		me (First, Middle,		ail	
ב	be fi	Be	17. Father's Name (First, Middle, L	asi)							1110)	
$\frac{8}{5}$	d Mer narka natic	၀	Ernest Purcell  19a. Informant's Name/Relationsh	in (Tuna Print)		19h Mailir	ng Address (Street a		ine Krau		n State. Zic	Code)
<u>s</u>	d 2 si th an 7 is r traur		Barbara C. Char		ece)		O New Ham					
ō,	1 an Heal tam 2		20a. Method of Disposition	105 (111	20b, Pl	ace of Dispo	sition (Name of		Date	20c. Location	•	
<u> </u>	ages ont of t: ff lt y or c		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		State		natory or other plac Cemetery	1	13-2005	Highla	nd M	arwland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Insportant: if Itam 27 is marked other than "natural; or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be rediffed at once.		21. Signature		III.	22	. Name and Addres	s of Facility				
Ba	Per		1 with		M01280	) \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	itzke Fun 555 Twin	eral Ho Knolls	mes, Inc. Road Col	umbia.	Marv	land 21045
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	caused the death							Approximate Interval Between
Ser.	Physician		Immediate Cause (Final disease or condition	iny one oddoo on	oudir ano.	Lh a	10 Sant	2 /				Onset and Death
	/Medical		resulting in death)	aDue to	(or as a consequ	uence of):	PERTENSIS	2//				unity.
	Examiner		Sequentially list conditions	b								
	P #	iner	Sequentially list conditions, it any, Isaumy to immediate cause. Enter Underlying	Sua to	(or as a nonsequ	ience of):						
V	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	(or as a consequ	ionco of):					-	
8760,	ate be executed hysician and the burial-transit	ai E			, (or <b>a</b> 0 a obilequ	301100 31).					1	
		dicai		d								
9 X	The law requires that the death certific to has been signed by the attending p rage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		-			23d. E	Date of deliv	ery
Box	death atter	iciar	in the past 12 months?	4□Preg	birth 2 □ Fetal nant at time of de		Ectopic pregnancy Other (specify)			h	<b>Jonth</b>	Day Year
o.	t the c by the ached	hys	9 Unknown	9Ll Unk	nown							
ر. ص	res tha	by P	Part II. Other significant condition	ns contributing to	death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use co		he cause of death?
ğ	w require been sig should b	edi							10	Yes 2 □ No	3 Prot	bably 4 Unknown
of Vital Records,	e law re has be je 2 sho	Completed							24a. Was		. Were auto	opsy findings available ompletion of cause of
Œ.		E C							perfo 1 ☐ Yes	med? 2 Z No	death? 1 ☐ Yes	2 <b>/3</b> -No
ī	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?						eath (Check only o	ne)		
<u>&gt;</u>	di S	2	1 ☐ Yes 2 ♣No			ER/Outpatie	-	4   Nursing	Home 5 9 lesio			fy)
D C		ion	27. Manner of Death 1 Matural 5 ☐ Pending	) (Mo	e of Injury onth, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ☐ No	28d. Describe	now injury occ	anea	
200	Attanding r death. actor: After by the fune	icat	2 Accident investig 3 Suicide 6 Could n	ot be 280 Place	e of Injury - At ho	ome farm et	reet, factory, office	163 2010	28f. Location (	Street and Nu	mber or Run	al Route Number,
Division	l or Attano after death Diractor: I in by the	ertification:	4 Homicide determine	ned buil	ding, etc. (Specif)	y) , tatti, st	000, 14000 y, 011100		City or Tox			
	To the Hospital or Attanwithin 24 hours after deatl To the Funaral Diractor:	0	29a. Certifier 12 Certifying	g Physicien: To th	ne best of my kno	wledge, deat	h occurred at the tir	ne, date and pla	ce, and due to the	cause(s) and	manner as s	stated.
	e Ho: 24 h e Fur letely	edical	(Check only 2 Medical to one)	examiner: On the	basis of examination	tion and/or in	vestigation, in my o	pinion, death oc	curred at the time,	date and plac	e, and due t	o the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	11	1		29c. Licens			29d. Date sig		
			Eur	Kland	10-		92	5947		wh	10,	2005
	d		30. Name and address of person	who completed car	use of death (Item	1 23a) (Type,	Print)					
	0		They style	Cun res	5540	TENE	TKSRP	corres	WHE on	va Ale	19	
	Sta		31. Date filed (Month, Day, Year) MAY 1 7 2	005 42	Registrar's Signa	ture	Print) TKS Ry					
	Regist	ar	MATICA	COO ME	A second	-						

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

		For State Registrar	State of Marylan	_	tificate of D		,	Reg. No.	005	1652
		Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
Physicia				Engle	-1		Month	Day	2005	7:11 AM
/Medic		Graham  e. Fecility Name (If not institution, give st	treet and number)	-7716	4b. City, Town, or L	ocation of Death	141604		unty of Death	7. 11.71.1
Examine	er	The TI II is		A	& A. C.	0 -1		10.00	only or oouth	
		The Johns Hopk		Jack high day)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	0 Right	place (State or Fore
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. M 2□ F 61	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Cour	try)
Director		214-42-1962	(iii -2.)	115.			12/1	.2/194	3 MD	
D		Usual Residence of Decedent  10a, State 10b, County	10c Ci	ty. Town or Loc	cation				1	Od. Inside City Limi
aryla Pho	.									1   Yes 2
W Land	용し	MD Baltimon	re Pa	arkvill	е					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene.  Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mcdical Examinar transite incitified at once.	i e	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
3a 6		10B Spindrift Circ	cle		21234			Unit	ed Sta	tes
ms 2	Funeral Director	11. Marital Status	2. Was Decedent Ever in U	l.S. 13. V	Vas Decedent of Hisp	panic Origin? (Sp	ecify Yes or No		Race - Americ	
The start	ᆵ	1 Never Married 2 Married	Armed Forces? 1 XYes 2 No		Yes, specify Cuban,		riican, etc.)		Black, White,	etc.
Irs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1960	0-1964	☐ Yes 2万No	Specify:		Sp	ecity: Whi	te
aftura 1		15. Decedent's Educ	ation	16a. Deced	ent's Usuai Occupati	ion		16b. Kind	of Business/In	dustry
U 0	Completed	(Specify only highest grade		(Give	kind of work done du OO NOT use retired)	ring most of work	ing	Jewe	lry	
that.	Ĕ	Elementary/Secondary (0-12) 12	College (1-4or 5+)	Jewe	ler					
Hygi nt,		17. Father's Name (First, Middle, Last)		1	1	8. Mother's Nam	e (First, Middle	, Maiden Su	mame)	
d la b	Be	Graham Dijon Engle	eman, Sr.				ona Wes			
Merke	္								Canala Zin	Codel
and and in m		19a. Informant's Name/Relationship (Type Dorothy Engleman	e, Print)		g Address (Street an					
Is 1 and 2 of Health a ltem 27 is other trau					Spindrift					
Of He		20a. Method of Disposition		Place of Dispo: cemetery, cren	sition (Name of natory or other place)		Date May 16		ion - City or To	own, State
oage ent cent ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	hesapea	ake Cremat	ory Inc.		Belt	sville,	Maryland
orter inju	- 1	21. Signature of Funeral Service License		CO 22	. Name and Address	of Facility				
Depa Impo any ii		A dial	1000		Cremation a 8717 Green					oweloud 2
ficate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a consecutive to (or a) consec	quence of):	on Cance	2				3 years
2 0 0	-									
he death certificate be r the attending physici ched for use as the bu	edical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 □	Ectopic pregnancy Other (specify)			230	d. Date of deliv	ery Day Year
that the death certificate by ad by the attending physici detached for use as the bu	edical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 death 5	Other (specify)	n in Part I.	23e. Did		Month	
rres that the death certificate be signed by the attending physici d be detached for use as the bu	edical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions con	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown  tributing to death but not re	al death 3 death 5 sulting in the u	Other (specify)	n in Part I.			Month contribute to	Day Year the cause of death?
requires that the death certificate by een signed by the attending physici hould be detached for use as the bu	edical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions con	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown  tributing to death but not re	al death 3 death 5 sulting in the u	Other (specify)	n in Part I.	1	tobacco use	Month  contribute to the second of the secon	Day Year the cause of death?
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law requires that the deam cent as been signed by the attending 2 should be detached for use s	edical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions con	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown  tributing to death but not re	al death 3 death 5 sulting in the u	Other (specify)	n in Part I.	1 24a. Wa	tobacco use	Month  contribute to 1	Day Year the cause of death? bably 4 Qunkno
The law requires that the death cert ate has been signed by the attending page 2 should be detached for use a	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions con meta state disease.	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown  tributing to death but not re	al death 3 death 5 sulting in the u	Other (specify)	n in Part I. 26. Place of Dea	1 24a. Wa auto per 1 Yes	tobacco use  Yes 2 1  s an  ppsy ormed? 28 No	Month  contribute to	the cause of death? bably 4 Qunknot opsy findings availal ompletion of cause of
Ine law fequires mar me deam cen ate has been signed by the attending page 2 should be detached for use a	Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions con meta state during s	1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown  tributing to death but not re	al death 3 death 5 sulting in the u	Other (specify)	26. Place of Dea	24a. Wa autroping 1 Yes	tobacco use  Yes 2 1 s an copsy formed? 2 No	Month  contribute to 1  No 3 □ Pro  24b. Were aut prior to co death?  1 □ Yes	Day Year the cause of death? bably 4 Munkno opsy findings availa mpletion of cause of
sing Prysicien: The law requires that the beart cent. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions con  Meta > table diseases  25. Was case referred to medical examiner?	1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown  tributing to death but not re	al death 3 death 5 death 6 dea	Other (specify)  Inderlying cause given  Int 3 DOA Other	26. Place of Dea	24a. Wa autroping 1 Yes	tobacco use  Yes 2 1 s an 2 s an 2 s one one) sidence 6 [	Month  contribute to 1  No 3 Pro  24b. Were autricular to condeath? 1 Yes  Other (Special	Day Year the cause of death? bably 4 Munkno opsy findings availa mpletion of cause of
ing Physician: The law requires that the death cert. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions con  Meta State due s  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending	1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown  tributing to death but not re c to the lu	al death 3 death 5 dea	nderlying cause giver  at 3 DOA Other  28c. Injury Work'  M 1 Y	26. Place of Dea T 4 □ Nursing Haat	24a. Wa authorist per 1   Year State   24a. Wa authorist   24a. Wa	tobacco use  Yes 2 1 s an ppsy pormed? 2 No one) sidence 6 6	Month  contribute to 1  No 3 pro  24b. Were autopior to condeath? 1 yes  Other (Special Special Specia	bably 4 Unknot opsy findings availad ompletion of cause of 2 No
ing Physician: The law requires that the death cert. After this certificate has been signed by the attending funeral director, page 2 should be detached for use a	Certification; To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No    25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death  1. Natural envestigation   29. Accident   3   Suicide   4   Homicide   Could not be determined    29a. Certifier   1   Certifying Physical in the past 12   Certifying Physical envestigation	1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown  tributing to death but not re c + The Lu  lospital: Valinpatient 2  28a. Date of Injury (Month, Day Year)	al death 3 death 5 dea	nderlying cause giver  at 3 DOA Other  28c. Injury Work' M 1 Y  reet, factory, office	26. Place of Dea  4 □ Nursing H  at ? es 2 □ No	24a. Wa aut per 1 Ves th (Check only ome 5 Res 28d. Describe 28f. Location City or To	tobacco use  Yes 2 1  s an posy ormed? 22 No one) sidence 6 [ how injury common, State)  e cause(s) are	Month  contribute to 1  No 3 Pro  24b. Were aut prior to co death? 1 Yes  Other (Special Cocurred)	baby Year the cause of death? bably 4 Unknot opsy findings availa ompletion of cause of 2 No  al Route Number, stated.
ing Physicien: The law requires that the death cert Aler this certificate has been signed by the attending funeral director, page 2 should be detached for use a	To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions con    Market   Market   Market   Market	Inpatient 2 Fet 4 Pregnant at time of 9 Unknown  Input of the last of the last of the last of line of the last of line of the last of examination of the last of the last of the last of examination of the last of the last of examination of the last of the last of examination of the last of examination of the last of the last of examination of the last of examination of the last of examination of the last of the last of examination of the last of the last of examination of the last o	al death 3 death 5 dea	nderlying cause giver  at 3 DOA Other  28c. Injury Work' M 1 Y  reet, factory, office	26. Place of Dea  4 □ Nursing H at ? es 2 □ No  e, date and place inion, death occu	24a. Wa aut per 1 Ves th (Check only ome 5 Res 28d. Describe 28f. Location City or To	tobacco use   Yes 2   1   s an	Month  contribute to 1  No 3 Pro  24b. Were aut prior to co death? 1 Yes  Other (Special Cocurred)	bay Year the cause of death? bably 4 Winknow opsy findings availa ompletion of cause of 22 No  ify)  ral Route Number, stated. to the cause(s)
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Œ			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H		and Mental H	ygiene Reg. No.	005	16529
			1. Decedent's Name (First, Middle, Last)					2. Date of E	eath	Year	3. Time of Death
	Physicia /Medic		CARL JOSEPH	ENGLISH				MAY	15,	2005	12:06P. M
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or		f Death	4c. 0	County of Death	
			707 E.LAKE AVE 5. Social Security Number 6. Sex	7 Ac	e (In yrs. last birthday)	BALTIM If Under 1 Year	ORE:	24 Hrs.   8 Date of F	lirth	N/A	place (State or Foreign
	Funeral Director			M 2□F 7		Months Days	Hours	Min. 8. Date of E Min. (Month, I August	23,1925	Ilfi	nois
	p .		Usual Residence of Decedent  10a. State 10b. County		10- Ch. T						40d Inside City Limits
	shov	ō			10c. City, Town or Lo						10d. Inside City Limits  YXYes 2 □ No
	28e-f	Director	Maryland N/A  10e. Street and Number	<u> </u>	Baltimo	10f. Zip Code			10g. Citiz	en of What Cou	
	3e or		707 East LAke Avenu	ıe		21	212		_	USA	
	death	Funeral	11. Marital Status	2. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi	ispanic Orig	gin? (Specify Yes or N , Puerto Rican, etc.)	No- 1-	4. Race - Ameri Black, White	
36	s after , or it		1 Never Married 2 Married	Armed Forces?  1/2/Yes 2 1  If Yes, Give	No WWII	1□Yes XXNo	Specify:	,			hite
Ö	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23e or 28e-f show int, the Madical Exaginer must be notified at	Completed by	3)(X)Widowed 4 ☐ Divorced	Year or Dates:	16a Decer	dent's Usual Occup	ation	<del></del>	16b Kin	d of Business/Ir	ndustry
75	be filed within 72 ho lal Hygiene. d other than "natu event, II. M. Jical	piet	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	during most	of working	TOD. TOTAL	a or basinosan	idddify
21	filed with Hygiene ther the int, Ite	Com	Lionionally Coolingary (o 12)	3		ngineer				lephone	
and	be d o d o	Be	17. Father's Name (First, Middle, Last) Patrick		English			r's Name <i>(First, Midd</i> Christine	le, Maiden S	Sumame)	Rossi
Ž	should be and Menta marked umatic ev	၉	19a. Informant's Name/Relationship (Typ.	ne. Print)				r or Rural Route Num	her. City or	Town State Zi	
S	ith ar lith ar 27 ia 27 ia		Christine I English					ue Baltimo			
ore,	07		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Loc	cation - City or T	own, State
<u><u>E</u></u>	Pages ment of I ent: If its ury or o		XX Burial 2 Cremation 3 Re	movai from State	Dulaney Val	ley Mausole	eum 5	/18/05	_	nium Ma	
Baltimore, Maryland 21215-0036	permit. Page Department of Importent: If any injury or once.		21 ignature of Funeral Service License	Kena	for 22	. Name and Addres		Mitchell-York Road B			al Home Inc and 21212
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused e cause on each li	the death. Do not ent	er the mode of dyin	g, such as	cardiac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ARTERIOS	CLEROTIC CA	RDIOVASC	ULAR 1	DISEASE			Onset and Death
	/Medical Examiner		Tosaking in dodany	Due to (or as	a consequence of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		a consequence of):						
	cuted nd ransit	Examiner	that initiated events								
, 0	e exe sian ar urial-t	EX	resulting in death) Last	Due to (or as	a consequence of):						
8760,	icate be executed physician and s the burial-transit	dicai	- 0								
Box 6	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome					2:	3d. Date of deliv	rery
	death of for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant a 9 Unknown		Ectopic pregnancy Other (specify)	'		-	Month	Day Year
P.0	that the de led by the a detached	Phy	9 ☐ Unknown  Part II. Other significant conditions con		out not regulting in the w	ndorhing course and	on in Dari I	23e Die	1 tobacco us	e contribute lo	the cause of death?
ords,	The law requires that the death certificate be executed tte has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	ted by	Part II. Other significant conditions con	modified to death a	out not resulting in the o	nderlying cause givi	en III Fait I.		Yes 2		1/
Records,	The law ricate has be page 2 sh	Completed						24a. Wa au pe	opsy formed?	prior to co death?	opsy findings available ompletion of cause of
Vital		0	25. Was case referred to medical				26. Place	of Death (Check only		1 🗆 Yes	2 140
of V	Phyaician: this certific ral director,	To B	X Yes 2 No	ospital: 1 🗆 Inpatio			er: 4 🗌 Nu	rsing Home 5 🗆 Re		ther (Speci	SCENE
o uc	ding P. h. After t funera	lon:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time of Injury	Worl	yat k? Yes 2.⊟i	28d. Describ	e how injury	occurred	
Division	r Attendii er death. rector: A by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, str		103 20	28f. Location			ral Route Number,
<u>S</u>	s after s after at Direct	Certification:	4 Homicide determined	building, et	tc. (Specify)			City or I	own, State)		
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (			of my knowledge, death of examination and/or in ated.						
	To the To the Comp	M	29b. Signature and title of certifier	1 ~	)	29c. Licens				signed (Month,	
•	*		l'arae!	tall	anna	1				16, 2005	
	10		30. Name and address of person who co				Stre	et Baltin	ore,	Marylan	d 21201
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 7 2	32. Resistr	rar's Signature	parke					

Eaton, Jack 51,2105 330pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 12. **Physician** 2005 3:30Рм Jack T. Eaton /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year Months Days if Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 80 206-16-1269 June 1924 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show other traumatic event, the Medical Examiner must be nutitied at 1 ☐ Yes 2√☐ No Howard Director Maryland Mount Airy 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with ŏ 21771 USA or Items 23a 1016 Bradford Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No 1942 If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 😾 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Tractor Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gwendllyn Davis 2 David C. Eaton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Importent: if Item 27 is many injury or other any injury or other 2008. Miriam Eaton, Wife 1016 Bradford Lane Mount Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 05/14/05 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Cremation Society Of Maryland Inc. Thomas Gregor 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) new **Physician** schomic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2,0 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 6 her (Specify) 2 1 Yes 2 No 5 Residence 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injuly occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State Registrar 6601

32. Registrar's Signature

BALAMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

NO

Chance

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Dalla A Steven Richard Erlanger 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner a. tal 101 Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
April 24,1958 New York 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Sex **Funeral** 1**∑** M 2□ F Yrs. 215-58-0417 47 April Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State in than "natural", or Itama 23a or 28a-1 show the Medical Examiner must be notified at 1 □Yes 2X No Director Baltimore Catonsville Maryland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 320 Lambeth Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housing 4 Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental is markad Richard Erlanger Florette Freedman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catonsville, MD 21228 f Health item 27 (Companion) 320 Lambeth Road Richard M. Steffe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition jo : 1 Burial 2 □ Cremation 3 □ Removal from State permit, Page Department o Important: If any Injury or Lakeview Cemetery 5-16-2005 Sykesville, Maryland ^ 4 □ Donation 5 □ Other (Specify) Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, MD 21228 21. Signature of Funeral Service Licen received 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final doys Physician disease or condition resulting in death) previous /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medicai the as Box use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.O. detached 9□ Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy has 1 ☐ Yes 21**X**(No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA 6 ☐Other (Specify) ို of 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined or A 4 Homicide within 24 hours a To the Funeral L To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 03306 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MAN

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

			1 - For Amend Items 23 in to of Maryland Caroline 1 - State Registrar Certificate of Death	lental Hygier	the second secon
	•		Decedent's Name (First, Middle, Last)	2. Date of Death	3. Fime of Death
	Physici	an	VESSIE LOUISE FELDMAN	Month O.5	Pay Year 3:50 PM
	/Medic	100	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death
40	Examin	ięr	GOOD SAMARITAN HOSPITAL BALTIMORE		
	Funeral Director		5. Social Security Number 220-18-609 1 M 2 F 7. Age (In yrs. last birthday) Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
			Usual Residence of Decedent	10 31 (	
	ylan		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mar-f sl	tor	ND BALTIMORE BALTIMORE		1 ☐ Yes 2 → No
	r 28	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	h wit		3732 E JOPPA KD 21236		USA
	deat Ims	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
9	or he		1 Never Married 2 Married 1 Yes, 2 No If Yes, Give 1 Yes 2 No Specify:	ritoari, oto.)	W 111
5-0036	hours after death with the Maryland lurel', or Itams 23e or 28e-1 show al Examination and be multilised at	i by	3 Widowed 4 Divorced Year or Dates:		Specify: WHILE
5	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)	in g 16b	. Kind of Business/Industry
2121	within ene. than "	du	Elementary/Secondary (0·12) College (1-4or 5+)		JUNE Horn
	e filed within al Hygiene. I othar than '	S	12 HOME VIAKER		Section 1 MAE
n	D = D =	Be	17. Father's Name (First, Middle, Last)  CLEUT AND CHRISTOPHER MARY	e (First, Middle, Maid	den Sumame)
Maryland	Mer	은		WHI	ILBY
lar	2 sho and Is ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura		5 P. C.
	1 and 1 Health Iam 27 othar tra	1 3	GILBERT FELDMAN, JR. Son 1949 GROWHILL KI		bere, MD 21227
o re	0 0	i î	1 Rurial 2 Cramation 3 Removal from State cemetery, crematory or other place)	2005	Location - City or Town, State
Ë		m,	'4 □Donation 5 □Other (Specify) (AR LUCE) CENETERY	- +	ERVILLE, MO
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility EVA  88000 1-100 Foet D		ackville, MD 21234
М		d I	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac on shock, or heart failure. List only one cause on each line.		Approximate Interval Between
	Physician		The Control (Clark	201	Onset and Death
7	/Medical		disease or condition resulting in death)  a. SEVERE PULMONARY HYPERTENS D  Due to (or as a consequence of):		
	Examiner		Interstitial lang	Disease	
		jer	sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	00101	
	be executed sictan and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	11	
ć	exection and ital-tr	Еха		N /11/	-2
8760	cate be e ohysician the buria	dical		, Conical	EXAMINER
68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	edi	Louis	PROVED BY MEDICAL	
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
B	death e atte d for	icia	1 Yes 2 Who 4 Pregnant at time of death 5 Other (specify)	<del> </del>	Month Day Year
0	at the de by the tached	hys	9 Unknown		
٦,	s thai	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
rds	w requires that been signed I should be det	p p	CORONARY ARTERIES DISCASE.	1 🗌 Yes	2 No 3 Probably 4 Unknown
Vital Records,	w rec	Completed		24a. Was an	24b. Were autopsy findings available
Re	The lav	щ		autopsy performed	
a		e C	25. Was case referred to medical 26. Place of Deat	1 ☐ Yes 2	No 1 Yes 2 No
Ξ		o Be	examiner?	h (Check only one)	e 6 ☐Other (Specify)
of	Phys r this ral di		27 Manner of Death 28a Late of Injury 28b Time of 28c Injury at	28d. Describe how i	
on	Attanding ar death. ractor: After by the funer	tio	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		
S	deat deat ctor: y the	lica	3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury · At home, farm, street, factory, office	28f. Location (Stree	t and Number or Rural Route Number,
Division	after Dira	Certification	4 Homicide determined building, etc. (Specify)	City or Town, S	tate)
	spita ours naral filled		29a. Certifier 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,	and due to the caus	e(s) and manner as stated.
	24 h	Medicai	(Check only and manner stated.  (Check only one)  Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		
	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
<b>)</b>	- 310		MATERIA MESWAY - M.D. RES 000	5	,14,2005
7	(0)		HBUGGRGL		, ,
	(10)		30. Name and address of person who completed cause of death (frem 23a) (Type, Print)  NTRWAN ABOUGERGE M.D., GOOD SAYAR.ITAN	1 HARDT	rA/
	Sta	te.	31. Date filed (Acopth, Day, Year) 32. Registrar's Signature	I IUVIL	1116
	Regist		MAY 1 7 2005 Keeper 25 April 20		

FELDMAN, JESSJE.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienel 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Carlene A. Ford 10 2005 11:32 p. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harbor Hospital Balto If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Hours 579-52-9914 1 M 2 XF D.C. 63 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examinar must be notified at 1 Ves 2 No Director N/A Md Balto 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö or Items 23a 3409 Round 21225 Funeral Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene "Andrea", or Ite 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Lutheran Hospital Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Importent: If item 27 is marked other tha any injury or other traumatic event, Imp 2006. Nurse 12th grade 4 vears 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alonzo Anderson Sarah Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marvin W. Ford, Jr - Son 3409 Round Road Balto, Md 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) ¹ 4 ☐ Denation Metro Crematory 5/16/2005 Catonsville, Md 21. Sign ture of Funeral Service 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 das /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the deeth certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ō Month Year in the past 12 months?
1 Yes No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes (No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ €R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 2 1 Tes this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 7 2005

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Day 1, 2005 12:58P M **Physician** Walter Hans Fremd /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Center Saint Joseph Medical Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** Months M 20F 216-20-4190 79 18 1925 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD Baltimore Timonium Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21093 USA 3 Kilglass Ct. Apt. 201 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Plant Engineer Brewery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Fremd Lena Zirkler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Walter H. Fremd/wife 3 Kilglass Ct. Apt. 201, Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/13/05 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21. Signature of Euneral Fervice Licenson <sup>22. Name and Address of Facility</sup>
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 Lowell M. Lemmon Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBELLAR HEMORRHAGE Physician /Medical Due to (or as a consequence of): Examiner THROMBOCYTOPENIA Sequentially list conditions, if any, leading to annicidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of): The law requires that the death certificate be executed physician and s the burial-transit MYF ODYSPLASIA Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only the Hospital: 1 Inpatient 1 Yes 2 No Other: 4 - Nursing Home P 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Mapner of D ath 28c. Injury at Work? 28a. Date of Injury After t Certification: 1 Natural 2 Accident 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 1th Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 05-11-05 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. R sistrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

JET Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-03357 Duane W. Froneberger Sr. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Froneberg W. 1) wane 14 2005 May 6:05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A 2700 Giles Road Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, Year) 963 5. Social Security Number 7. Age (In yrs. last birthday, Funeral 214-78-8549 Months 10X M 2□ F Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at Baltimore Maryland 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Kound Koad Apartment ö tates 2602 21225 United or Items 23a Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Wire Company than Elementary/Secondary (0-12) College (1-4or 5+) 12 abover 4.2 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) roneberger haw larence Jean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Prin permit. Pages 1 and 2 st Department of Health and Important: If item 27 Isn any injury or other traun Road Apartment B-1 Balto. Md. 2/323 Fromberger Nother 2602 Jean Kound 20b. Place of Disposition (Name of cemetery, crematory or other place) May Date 2/ 20c. Location - City or Town, State 20a. Method of Disposition Lansdowne, Maryland 1 ■ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 2005 Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address, of Fapility Aug. Juneral Service, P.A. Calvin L. Willia P.O. BOX 11651 Bultimore, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gunshot Wounds utiple Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been sign page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth?

1 □ Yes 2 □ No 1X Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 V Other (Specify) Scene Hospital: XXYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2

Division of Vital Records, P.O. Box 68760 of or Attending Physicien: after death. this tuneral Atter Director:

27. Manner of Death 1 Natural 5 Pending 2 Accident Suicide 3 Suicide
4 Homicide

investigation 6 Could not be determined

28b. Time of 28a. Date of Injury (Month, Day Year) 14/05

Local

28c. Injury at Work? Found 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 🗖 No

28d. Describe how injury occurred

5 unlect Shot 28f. Location (Str. st and Number or Rural Route Number, City or Town, State) 2700 (185 Rd Backmerery

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

lauma

29c. License number OCME

РМ

Year

May 15 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street Baltimore, Maryland 21201 CHRO ma

Street

State Registrar

Certification:

Medical

31. Date filed (Month, Day, Year) MAY 1 7 2005

within 24 hours a To the Hospitel

Funeral Director    Social Security Number   S	10d. Inside City Limits 1 ▼Yes 2 □ No ten of What Country? J.S. 4. Race - American Indian,
Medical Examiner   VICHNIA   4a. Facility Name (If not institution, give street and number)   4b. City, Town, or Location of Death   4c. (Institution)   4c. (Instit	County of Death  N/A  9. Birthplace (State or Foreign Country)  Mary Land  10d. Inside City Limits  1  Yes 2 No  ten of What Country?  J.S.  4. Race - American Indian,
Funeral Director  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. City  BALL WALE  5. Social Security Number  6. Sex  1 Months  7. Age (In yrs. last birthday)  10 City Town or Location of Death  4c. City  BALL WALE  5. Social Security Number  6. Sex  1 Months  1 Days Hours  Min. Month, Day, Year)  April 26, 19  Usual Residence of Decedent  100 States  100 County  100 City Town or Location of Death  4c. City  Ab. City, Town, or Location of Death  4c. City  Ab. City Town, or Location of Death  4c. City  Ab. City Town, or Location of Death  4c. City  Ab. City Town, or Location of Death  4c. City  Ab. City Town, or Location of Death  4c. City  Ab. City Town, or Location of Death  4c. City  Ab. City Town, or Location of Death  4c. City  Ab. City Town, or Location of Death  4c. City	County of Death  N/A  9. Birthplace (State or Foreign County)  Maryland  10d. Inside City Limits  1  Yes 2 No  ten of What Country?  J.S.  4. Race - American Indian,
Funeral Director  5. Social Security Number  6. Sex 1 M 2 St F 82  1 M 3 ST F 82	9. Birthplace (State or Foreign Country)  Mary Land  10d. Inside City Limits  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Funeral Director  5. Social Security Number  218 18 5728  6. Sex 1 Months Days Hours Min.  6. Sex 1 Months Days Hours Min.  8. Date of Birth (Month, Day, Year) April 26, 19  Usual Residence of Decedent	10d. Inside City Limits 1 ★ Yes 2 No ten of What Country? J.S. 4. Race - American Indian,
Usual Residence of Decedent	10d. Inside City Limits 1 ★ Yes 2 No ten of What Country? J.S. 4. Race - American Indian,
Usual Residence of Decedent	10d. Inside City Limits 1 ★ Yes 2 No ten of What Country? J.S. 4. Race - American Indian,
10a. State   10b. County   10c. City, Town or Location	1 Try Yes 2 □ No ten of What Country?  J.S.  4. Race - American Indian,
Maryland N/A Baltimore    10e. Street and Number   10f. Zip Code   10g. Citiz	zen of What Country?  J.S.  4. Race - American Indian,
10f. Zip Code  10g. Citiz  3803 - 8th Street  10f. Zip Code  10g. Citiz  21225  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1	J.S. 4. Race - American Indian,
3803 - 8th Street  21225  11. Marital Status  1	4. Race - American Indian,
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 XWidowed 4 Divorced  1 Specify only highest grade completed)  13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Ones are the specific of this panic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Ones are the specific of this panic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
1 Never Married 2 Married 1 Yes, Give Year or Dates:  1 Never Married 2 Married 1 Yes, Give Year or Dates:  1 Never Married 2 Married 1 Yes, Give Year or Dates:  1 Never Married 2 Married 1 Yes 2 No Specify:  1 Never Married 2 Married 1 Yes, Give Year or Dates:  1 Never Married 2 Married 1 Yes 2 No Specify:  1 Never Married 2 Married 1 Yes, Give Year or Dates:  1 Never Married 2 Married 1 Yes 2 No Specify:  1 Never Married 2 Married 1 Yes, Give Year or Dates:  1 Never Married 2 Married 1 Yes, Give Yes or Dates:  1 Never Married 2 Married 1 Yes, Give Yes or Dates:  1 Never Married 2 Married 1 Yes, Give Yes or Dates:  1 Never Married 2 Married 1 Yes, Give Yes or Dates:  1 Never Married 2 Married 1 Yes, Give Yes or Dates:	Black, White, etc.
To be a second of the second o	Specify: White
Lib Specify only highest grade completed) (Give kind of work done during most of working	
life. DO NOT use retired)	nd of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+)  12th  College (1-4or 5+)  Elementary/Secondary (0-12)  College (1-4or 5+)  Earnings Analyst  Soci	ial Security
The state of the s	•
Elementary/Secondary (0-12)  To be a company of the	·
RODERT DETASHMUTT IMAUG Kennedy  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or	Town, State, Zip Code)
Ginny Stein / Daughter 5912 Linthicum Lane Linthicum, N	Maryland 21090
Ginny Stein / Daughter 5912 Linthicum Lane Linthicum, N  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory of other place)  20c. Loc	cation - City or Town, State
1 (X) Burial 2 Cremation 3 Removal from State  1 (A) Donation 5 Other (Specify)  MD State Veteran Cem. 5/13/2005	nsville, Maryland
20a. Method of Disposition  1 Ck Buriai 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  MD State Veteran Cem. 5/13/2005 Crow  21. Signature of Fineral Service Licensee  22b. Place of Disposition (Name of cemetery, crematory or other place)  MD State Veteran Cem. 5/13/2005 Crow  22c. Name and Address of Facility Gonce Funeral	
21. Signatur of Firneral Service Licensee 22. Name and Address of Facility Gonce Funeral 4001 Ritchie Highway Baltimor	and the second s
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin	Approximate
Immediate Cause (Final	Interval Between Onset and Death
/Medical disease or condition resulting in death)  a  Due to (or as a consequence of):	8 ववपुड
Examiner Scots	Ca denie
Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of):	D 00042
if any, leading to immediate cause finited linder/sin Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Co.  Due to (or as a consequence of):	5 Jears
The sulfting in death) Last Due to (or as a consequence of):	3 9 651 5
Pen ne be ne	
as this as the state of the sta	
Work of the post o	3d. Date of delivery
in the past 12 months?  in the past 12 months?  I Description of death  I Desc	Month Day Year
1   Yes 2   Who 9   Unknown 9   Unknown 9   Unknown 23e. Did tobacco us	
	se contribute to the cause of death?
D TO THE TOTAL COMINE TYPE KALEMIA 1 Yes 2 E	No 3 Probably 4 □Unknown
HYPERCALEMIA  1 Yes 2 E  24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of
	death? 1 Yes 2 No
1   Yes   2   No   No	
Hospital: 1 Propatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6	Other (Specify)
27. Manney of Death 28a. Date of Injury 28b. Time of Injury Work?  27. Manney of Death 28d. Describe how injury Work?	occurred
USING Section (Street and Section Sect	
27. Mannar of Death 1	Number or Rural Route Number,
Cer ital o o la ital o o la ital o o la ital o o o la ital o o o o o o o o o o o o o o o o o o o	
Description of the first of the	and manner as stated.
and manner stated.	
	signed (Month, Day, Year)
MAN RES DOD MAN	(11,2005
Name and address of Jerson who completed cause of death (Item 23a) (Type, Print)  AUSTARIAL COM 300 SOVIETH HAVEL STEAT BATTIMORE	V
CHRISTOPHER KOH SOOI SOUTH HANGUER STREET DAITIMORE	MARKIAND 21225
State Registrar  State  MAY 1 7 2005	

Ann Fisher 05-03259 RPD

	RPD		1 - For Stete Registrar		aryland / Depa <i>Cei</i>	artment of H rtificate of L			ene g. No.	05	16537
	Physici		1. Decedent's Name (First, Middle,		HER			2. Date of Death May 10,	2005	Year	3. Time of Death 0256 P M
	/Medio Examir		4a. Facility Name (If not institution,	give street and number)			Location of Death			y of Death	0200 1
			710 Pennsylvania 5. Social Security Number		e (In yrs. last birthday)	Baltimor	e If Under 24 Hrs.	O Data of Birth		N/A	
ľ	Funeral Director		218-42-3616	1 ☐ M 2 ဩ F	61 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 6-23-1	<sup>Year)</sup> 943	9. Birth	olece (State or Foreign ntry) LAND
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Maryl.	tor	MD. N/A		BALTIMOR						1X Yes 2 □ No
	or 28s	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Cou	ntry?
	s 23a	ral	710 PENNSYLVANI			21217			USA		
5-0036	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show algal Examinat must be notified at	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:	io I	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2∑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	ce - Americ ck, White, y: BLA	etc.
0-6121	s within 72 ho plene. r than "natur the Medical.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of work	ing 1	6b. Kind of B		
Z	filed Hyg thar		-12- 17. Father's Name (First, Middle, La	-0-	DISA	BLED	18. Mother's Name	e (First, Middle, M		ABILI	TY
lan		ro Be	DOUGLAS FISHER					ABETH GO		,,,,	
lar)	l 2 sho and f is ma rauma		19a. Informant's Name/Relationship			ng Address (Street a					
<u>မ</u> (မှ	1 and Health tam 27		LINDELL FISHER (	BRUIHER)	20b. Place of Dispo	OLD MILL sition (Name of			MARY LA  Oc. Location		
altimor	Pages nent of int: ff i		1 ☐ Burial 2 ② Cremation 3 1 ☐ Donation 5 ☐ Other (Spe	☐Removal from State cify)	METRO CRE	natory or other place MATORY	5-14-			•	(ARYLAND
gall	permit. Pages 1 and 2 should be Department of Health and Menta Important: if itam 27 is marked any injury or other traumatic avonce.		21. Signature of Euraral Service Lin	ensel ONATHAN	D. HIBNER22	. Name and Address	s of Facility PHI	LLIPS FU	NERAL	HOME,	P.A.
	407 40	10	23a. Part1. Enter the disease, or co	emplications that caused	the death. Do not enti				-	MARYL	AND 21217 Approximate
,	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	rasulent a consequence of):	ri (aydi	4				Interval Between Onset and Death
on,	irate be executed physician and sthe burial-transit	I Examiner	Sequentially list conditions, it any, leading to himself at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
na/sa xaa	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the decedent pregnant	d		Ectopic pregnancy				te of delive	,
5	the dea y the a ched fo	ysic	in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of death 5	Other (specify)			Mic	onth	Day Year
ecolus, r	w requires that the death certil been signed by the attending should be detached for use a	by	Part II. Other significant conditions The Fes	contributing to death bu	ut not resulting in the un	iderlying cause give	n in Part I.	23e. Did toba	A./		ne cause of death?
	rsician: The law re certificate has be lirector, page 2 sho	Completed					<del></del>	24a. Was an autopsy performe	ed2	Were autoprior to condeath?	psy findings available inpletion of cause of
N N	s certif	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatien	Other		(Check only one)			10t com
5	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injury Work		me 5 Hesiden 28d. Describe how			at scene
	To tha Hospital or Attandii within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	Certification	3 Suicide 6 Could not determine		ry - At home, farm, stre . (Specify)	eet, factory, office		28f. Location (Stre City or Town,		er or Rura	l Route Number,
	a Hospi 24 hou a Funar etely fill	edical	29a. Certifier (Che Cony one)  Certifying 24 Medicel Ex	Physicien: To the best of eminer: On the basis of and manner state	examination and/or inv	occurred at the time estigation, in my opi	e, date and place, a nion, death occurr	and due to the cau ed at the time, date	se(s) and ma and place,	inner as st and due to	ated. the cause(s)
	To th within To the	Me	29b. Signature and little of dertifier	1		29c. License		1	I. Date signe		
			1 ( Ltst	emp		OCME		Ma	ay 11,	2005	
	7		30. Name and address of person who	The five	nath (Item 23a) (Type, F	111 Penn	Street 1	Baltimore	, Mar	yland	21201
	Sta Registra		31. Date filed (Month, Day, Year)  MAY 1 7 2	457	r's Signature	the)					

			State of Maryland / Department of Health and Mental Hygiene  1 - State Namend Item 25 per Verb., G843, 05/11/105dhb /MR  Registrar  Registrar
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  CAROLE ANN GREEN  2. Date of Death Month Day Year 05-12-2005  1: 30 PM
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4d. ANNE ARUNDEL  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24 Hrs.   8. Date of Birth  9. Birthplace (State or Foreign)
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F  One of the security Number Country  One of the security Number Country  One of the security Number  One of the security Number
	r 28a-f show	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 KNo
	sath with the 23s or 29	Funeral Director	10e. Street and Number  3471 ANDREW CT. # IOI 20707 USA
980	72 hours after death with the Maryland natural', or items 23s or 28s-f show dical Exacting trust be redified at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  1 Yes, Specify: BLACK
21215-0036	c * 35	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12. TH GRADE:  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  NURSES ASSISTANT  HEALTH CARE
	be filed stal Hygi od other event, I	To Be Co	12.7H GRADE N/A NURSES ASSISTANT HEATH CARE  17. Father's Name (First, Middle, Last)  LAWRENCE HERBERT  18. Mother's Name (First, Middle, Maiden Sumame)  EVELYN PETERSON
, Maryland	S as as	F	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  EUGENE GREEN (HUSBAND) 3471 ANDREW CT. + 101 LAUREL MD 20707
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  CROWNS VILLE 05.18.05  CROWNS VILLE MD
Balt	permit. Departi		21. Signature of Funeral Service License VAUGHAY C. GREENE FUNERAL SERVICE 5151 BALTO. NATU PHYE, BALTO. MD 21229
	Physician /Medical		23a. Part1. Entér the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death  Onset and Death
	Examiner	er	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):
, 0,	be executed sician and burial-transit	i Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):
x 68760,	leath certificate b attending physic I for use as the bi	/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
P.O. Box	iaw requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1   Yes   2 the past 12 months? 1   Yes   2 the past 12 months? 9   Unknown   23c. If Yes, outcome of or pregnancy of pregnancy   23c. If Yes, outcome of or pregnancy   23c. If Yes, outcome of pregnancy   23c. If Yes, outcome of or pregnancy   23c. If Yes, outcome of pregnancy   23c. If Yes,
	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   No   3   Probably   4   Unknown
I Reco	The ate ha page	Completed by	24a. Was an autopsy performed?  1 □ Yes 2 ▼ No 1 □ Yes 2 ▼ No 24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital Records,	Physician: this certific al director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No 1 Mospital: 1 Nonpatient 2 ER/Outpatient 3 DOA 28c. Injury at 28d. Describe how injury occurred
ision	Attending r death. sctor: After by the funer	Certification;	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be contained and the country of the country
Dİ	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director:		4 ☐ Homicide building, etc. (Specify)  29a. Certifier (Check only)  1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	3		Jamel Held 0053235 5//3/05  30. Name and address of person the completed cause of death (Item 23a) (Type, Print)  DARRYL HILL 13635 BALTIMORE AVE. LAUREL MD
	Sta Regist		DARRYL HILL 13635 BALTIMORE AVE. LAUREL MD  31. Date filed (Month, Day, Year)  MAY 1 7 2005 Baltimore Mo

			1- For State of Maryland / Department of Health and N Certificate of Death	Mental Hygie	-	16539
	Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	/Medi Examir	cal	Herbert James Gray, Jr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	5	14 2003 4c. County of Deat	
	LAGIIII	161	North Arundel Hospital alen Burnie	mo	Anne A	1 1
	Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Date of Birth Month, Day, 3		thplace (State or Foreign buntry) MD
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	03/23/	1320	
1	within 72 hours after death with the Maryland ane	tor	MD Anne Arundel Pasadena			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
4	vith the	Direc	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	ountry?
_8_	death w	eral	235 Carroll Road 21122  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Road)		U.S.A.	since Indian
ه کو	or Iter	/Fun	1 Never Married 2 Married Armed Forces?  1 Armed Forces?  1 Kyes Give No 1945 -	Rican, etc.)	Black, White	
ان ان حلہ	2 hours atural, cal Ex	Completed by Funeral Director	15. Decedent's Education 16a Decedent's Usual Occupation	16	Specify: Wh	nite
) 2 2 2 1 2 1 2	within 7; iene. than "na	nplet	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of works life. DO NOT use retired)	ing	commodity	*
4 Z Z	Hygie ther int.	Cor	9 Mechanic Foreman  17. Father's Name (First, Middle, Last) 18. Mother's Name	Me (First, Middle, Ma	lerchandi	se
)		To Be			ebrowski	
Mary	and and lam	4	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural)	al Route Number, C	City or Town, State, Z	Zip Code)
	ss 1 and 20 Health item 27 other tra		Margie Gray / Wife 235 Carroll Road,  20a. Method of Disposition  1 M Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of commetery, crematory or other place)		a, MD 21 Oc. Location - City or	
altimore,	Pages ment of ant: If i		1 ☑ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Meadowridge Mem Pk 05/		·	
Ball	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.	J.Gonce	Funeral	Home, PA
	4		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	ve, Pas	adena, M	Approximate
	Physician		Immediate Cause (Final disease or condition			Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	19	T.C. +	,
1	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ocardial:	1419101	12 hours
V	xecuter and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	<b>&gt;</b>		,
8760,	cate be executed obysician and the burial-transit	dical E	d.			
9	ertifical fing phy e as th	Medi	IF FEMALE:			
Вох	death certifica attending pt for use as th	clan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delin	very Day Year
Divislon of Vital Records, P.O.	t the c by the tached	Physiclan/Me	9 Unknown 9 Unknown			
ds, l	signed be de	l by	Part II. Dither significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Prior Myocardal Infanction		cco use contribute to	
COL	sw requir s been si should	letec	1 0 000 000	24a. Was an		obably 4 Arknown copsy findings available
I Re	The law cate has page 2 s	Completed by		autopsy performed	prior to co	ompletion of cause of
Vita	sician: Th certificate irector, pag	o Be (	25. Was case referred to medical exampler?  Hospital: 20 EP/Outscline: 20 Do. Other: 2	(Check only one)		
ĵοt	ding Phys I. After this funeral di	<b>├</b> ──	1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Hon 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	ne 5 Residence 28d. Describe how i	e 6 □Other (Speci injury occurred	ify)
Sion	ttandir death. stor: Af	Certification:	2 Accident investigation M 1 Yes 2 No			
Div	al or Attand s after death I Director: / d in by the f	ertif	4 Homicide  determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	Hospita 4 hours Funera ely fille	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are composition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place are composition of the basis of examination and/or investigation, in my opinion, death occurred at the composition of the basis of examination and/or investigation and the composition of the composit	and due to the caus	se(s) and manner as	stated.
	ple ple		one) and manner stated.  29b. Signature and title of certifier 29c. License number		and place, and due to a signed (Month,	
	⊢ s ⊢ ŏ					
_	(e+1		Mle A Solaeffee, uns D0015685  30. Name and address of person who completed cause Heath (Item 23a) (Type, Print)  Allen H. Schaeffer mp Annadel Heart Assoc		- U A	0
	Stat	•	Allen H. Schaeffer mo Arundel Heart HSSGC  31. Date filed (Month, Day, Year)  32. pregistrar's Signature	1600 ( 1-91	n Hwy lile	in Burnie Al
	Registre	T.	MANY 4 W OCCUPY AND A MANY AND			

DHMH 17 Rev 1/2001

			Please Type or Print in Black	k Indelible Ink	. Ensure All Copie	s Are Legible.	
			State of Maryland / D		Health and Mental H		1 2 20 1 40
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of	2 Date of I		3. Time of Death
	Physici /Medi		Leonard John Gizinski		Month	14 ons	8-15P M
	Examir	er	4a. Fecility Name (If not institution, give street and number)  NOTH ARUNDEL HOEPTA		or Location of Death	4c. County of Dea	APPLICATED OF L
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	0 -1 301			thplace (State or Foreign ountry)
	Director		214-14-8334 1 <sup>₾M 2□F</sup> 85	Yrs. Days	Hours Min. 8. Date of E (Month, Aug 29	, 1919 Ma	aryland
	ryland thow		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	the Ma	ecto	Maryland Howard Elkri  10e. Street and Number			10= Cities= of Mh = 10	1 ☐ Yes 2Ã No
	within 72 hours after death with the Maryland ene. than "neturel", or Itema 23a or 28a-f show to Madical Examiry master rediffical at	Funeral Director	6441 Montgomery Road	10f. Zip Code	21075	10g. Citizen of What C	
	r deetl	ıner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	Hispanic Origin? (Specify Yes or I an, Mexican, Puerto Rican, etc.)	No- 14. Race - Am Black, Whi	
36	or, or la	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give 3 💆 Widowed 4 ☐ Divorced Year or Dates:	1□Yes 2X No		Specify:	White
5-0	72 hou		15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occup (Give kind of work done	during most of working	16b. Kind of Business	s/Industry
21215-0036	within ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Steam Fitt	,	Pipe Fit	ting
	be filed within 72 hartal Hygiene. Id other than "netu	Be C	17. Father's Name (First, Middle, Last)	Decam III	18. Mother's Name (First, Midd	le, Maiden Sumame)	CING
Maryland		101	Constantine Gizinski  19a. Informant's Name/Relationship (Type, Print)  19b.	Marillan Address (Casas)	Constance Unl		7-0-4-)
	od 2 27 Is r trau			-	and Number or Rural Route Num ery Road, Ellico		
Baltimore,	permit. Pages 1 and 2 Department of Health Importent; If item 27 I any Injury or other tra once.		1 E-FOUNDI 2   CHOINGUIN 3   MONIOVALINON SIGNO	Disposition (Name of y, crematory or other place ROSary Cemet	Date Date Cery 5/18/05	20c. Location - City of Baltimore,	
Balti	permit. Pages Department of Importent; If it any Injury or o		21. Signature of Funeral Service Licenses	22. Name and Addre	ess of Facility Hubbard I ens Avenue, Balt	uneral Home	, Inc.
			23a. Part1. Enter the disease of complications that caused the death. Do n shock, or heart failure. List only one dause on each line.				Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	PILLATION			Sinset and Death
н	Examiner		Due to (or as a consequence of	xf): -			1048ASA
	p #	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				25010 20
	xecuted and al-transit	Exam	Cause (Disease or injury that initiated events resulting in death) Last	<u> </u>			25 EATS
68760,	licate be exec physician an s the burial-tr	calE	d				
x 68	ertifica ling ph e as th	Med	IF FEMALE:				
Box	The law requires that the death certificate be exe tite has been signed by the attending physician a page 2 should be detached for use as the burial-	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	y	23d. Date of de Month	livery Day Year
P.0	that the de led by the detached		9 ☐ Unknown  Part II. Other significent conditions contributing to death but not resulting in	the underlying cause giv	ven in Part I. 23e. Did	tobacco use contribute t	o the cause of death?
rds,	w requires been sign should be	ed by			1[	Yes 2 No 3 P	robably 4 Ninknown
Records,	law re las bee	Completed			24a. We	is an 24b. Were a prior to	utopsy findings available completion of cause of
al B					per 1 Ves	tormed? death?	_/
f Vital	ysic is ce direc	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☑ Appatient 2 ☐ EP/Out	tpatient 3 DOA Oth	26. Place of Death (Check only ier: 4 □ Nursing Home 5 □ Re		ecify)
n of	ng Pt fter th	on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. T	ime of 28c. Injury	y at 28d. Describ	e how injury occurred	
Division	Attending ir death. ector; After by the fune	ficati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far		Yes 2 □ No 28f. Location	(Street and Number or R	ural Route Number.
D	2 th 2	Certification:	4 Homicide determined building, etc. (Specify)	,		own, State)	- 5-,
	To the Hospital or within 24 hours after To the Funerel Director completely filled in the Funerel Director of the Funerel Dire	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the tir for investigation, in my o	me, date and place, and due to the ppinion, death occurred at the time	e cause(s) and manner a e, date and place, and du	s stated. e to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	29c. Licens		29d. Date signed (Mon	th, Day, Year)
•	0		1 Dary		45149	11/1920 15	2005

Registrar
DHMH 17 Rev 1/2001

State

30 Name and address of person who completed a solution of the 
10

accause of death (Item 23a) (Type, Print)

TOCP (Told Of See

37 Registrar's Signature

· Elen Burrie

MO

21061

Physician   Medical   Examiner   4a. Fecility Name (If not institution, give street and number)   4b. City, Town, or Location of Death	2. Date of Death Month Day Year 3. Time of Death Month Cay Year 4c. County of Death
Medical Examiner  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4b. City, Town, or Location of Death  4c. Fig. 15	may 12 200 - 5-66AM
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Ht Under 1 Year If Under 24 Hrs. If	4c. County of Death
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8  Months Days Hours Min.	De a a a
Funeral Months Days Hours Min.	Baltinasa
Director 220-10-0015	(Month, Day, Year) Country)
Usual Residence of Decedent	ig. 2, 1918   Maryland
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Baltimore Arbutus	1 ☐ Yes 21 No
10e. Street and Number	10g. Citizen of What Country?
10a. State 10b. County 10c. City, Town or Location  Arbutus  10a. State 10b. County MD Baltimore 10f. Zip Code 21227  11a. Marital Status 12b. Married 2 Married 12b Married 1	USA
12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri	rfy Yes or No- ican, etc.) 14. Race - American Indian, Black, White, etc.
1 □ Never Married Ž	te Specify: White
15. Decedent's Education 16a. Decedent's Usual Decupation	16b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Truck Driver	
Elementary/Secondary (0-12)  College (1-4or 5+)  Truck Driver  18. Mother's Name (First, Middle, Last)	FJ Boutelle
17. Father's Name (First, Middle, Last)  18. Mother's Name (	First, Middle, Maiden Sumame)
	chomv
20a. Method of Disposition 1 28urial 2 Cremation 3 Removal from State 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 28urial 2 Cremation 3 Removal from State 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 20c. May 17, 0 20c. Method of Disposition 20c. Method of	
1 Paurial 2 Cremation 3 Removal from State  1 Paurial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  21. Signature of Funeral Service Lensee  22. Name and Address of Facility Louder  3620 Wilkens Ave. Ba	
21. Signature of Funeral Service Lensee 22. Name and Address of Facility Loude	on PArk Funeral Home ltimore, Maryland 21229
3020 WIREIS AVE. Ba.	
23a. Part. Enter the disease, or complications that galsed the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Interval Between Onset and Death
Physician disease or condition a. (Medical resulting in death)	
But it (or as a consequence or).	
Sequentially list conditions, b. Due to for as a consequence of	
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
Due to (or as a consequence of):	
Penns of the property of the p	
Cause (Disease or injury that infliated events resulting in death) Last  Cause (Disease or injury that infliated events resulting in death) Last  Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown    Cause (Disease or injury that infliated events resulting in death) Last    Cause (Disease or injury that infliated events resulting in death) Last    Due to (or as a consequence of):    Due to (or as a consequence of):    Due to (or as a consequence of):    Cause (Disease or injury that infliated events resulting in death) Last    Due to (or as a consequence of):    Cause (Disease or injury that infliated events resulting in death) Last    Due to (or as a consequence of):    Cause (Disease or injury that infliated events resulting in death) Last   Cause (Disease or injury that infliated events resulting in death) Last   Due to (or as a consequence of):    Cause (Disease or injury that infliated events resulting in death) Last   Due to (or as a consequence of):    Cause (Disease or injury that infliated events resulting in death) Last   Cause (Disease or injury that infliated events resulting in death) Last   Due to (or as a consequence of):    Cause (Disease or injury that infliated events resulting in death) Last   Due to (or as a consequence of):   Cause (Disease or injury that infliated events resulting in death) Last   Cause (Disease or injury that infliated events resulting in death) Last   Cause (Disease or injury that infliated events resulting in death) Last   Cause (Disease or injury that infliated events resulting in death) Last   Cause (Disease or injury that infliated events resulting in death) Last   Cause (Disease or injury that infliated events resulting in death) Last   Cause (Disease or injury that infliated events resulting infliated	
Define the past 12 months?  23c. If yes, outcome of pregnancy  1	23d. Date of delivery  Month Day Year
O e to	
	23e. Did tobacco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 Unknown
Completed	24a. Was an 24b. Were autopsy findings available
Compi	autopsy prior to completion of cause of death?
	1 Yes No 1 Yes 2 No
25. Was case referred to medical examiner?  1	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28c. Injury at 28c. Injury 28b. Time of 28c. Injury at 28c. Injury 28b. Time of 28c. Injury at 28c. Injury 3 Work?	d. Describe how injury occurred
O D S S S S S S S S S S S S S S S S S S	
2 State 2 Accident Investigation	8f. Location (Street and Number or Rural Route Number, City or Town, State)
2 Accident investigation   M 1 Yes 2 No  2 Suicide   Accident   Ac	
Serio 2 4 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 28	
2 Accident 3 Suicide 4 Homicide 2 Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  2 Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  2 Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  2 Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  2 Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
2 Accident 3 Suicide 4 Homicide  2 Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  2 Sp. Signature and title of certifier 3 Suicide 4 Sp. Place of Injury - At home, farm, street, factory, office 2 Sp. Place of Injury - At home, farm, street, factory, office 3 Sp. Place of Injury - At home, farm, street, factory, office 3 Sp. Place of Injury - At home, farm, street, factory, office 4 Sp. Signature and title of certifier 3 Suicide 4 Sp. Place of Injury - At home, farm, street, factory, office 4 Sp. Signature and title of certifier 4 Sp. Signature and title of certifier	d at the time, date and place, and due to the cause(s)
trail in the local control of	
29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only one)  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number	d at the time, date and place, and due to the cause(s)
2 Accident 3 Suicide 4 Homicide 6 Could not be determined 2 Be. Place of Injury - At home, farm, street, factory, office 2 building, etc. (Specify)  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.  29b. Signature and title of certifier 29c. License number  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	d at the time, date and place, and due to the cause(s)
29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only one)  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number	d at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Day **Physician** 2005 Year 14, **JOHN** Η. GRIFFIN 6:50 ам /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE CITY MARYLAND GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 14, 1928 **Funeral**  Birthplace (State or Foreign Country) Hours 125M 2□F Months Days Yrs. Maryland 77 218-22-1579 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Example results to notified at 10d. Inside City Limits Director 1 XYes 2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5803 Royal Oak Avenue 21207 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be tiled within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No
If Yes, Give
Year or Dates: 47-49 1 Never Married 21X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be tiled within 72 Department of Health and Mental Hygiene. important: if itam 27 is marked other than "na any injury or other traumatic event, it a Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 9th Bail Bonds Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jimmy White Eva Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Williams / Wife 5803 Royal Oak Avenue Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Cem.! 5-23-05 Owing Mills, Md. 21. Signat r of Funeral Service Licen 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002 23a. Part 1. Enter the disease, o complications that caused the death. Do ot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARCTION IMMEDIATE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, in J. Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown 24a. Was an autopsy performed? 1 ☐ Yes 2 🗓 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 after death.

Director: After this certitic
I in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide tilled 24 hours a Medical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D15140 May 17, 2005 30. Name and address of person who completed cause of death (Item \$3a) (Type, Print) Ian Sunshine, M.D. 6210 Park Heights Ave. Baltimore, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 7 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death R. GANZETT **Physician** Mth 11:85 14 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Manor Home Ellicott City
If Under 1 Year | If Under 24 Hrs. Howard 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug 5, Birthplace (State or Foreign Country) 1 □ M 2 점 F Months Days Hours 89 Yrs. Director 213-10-5070 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or items 23a or 28e-1 show other treumatic event, Ite Modical Examiner is ust be notified at Directo Maryland 1 ☐ Yes 2 XNo Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2992 Normandy Drive 21043 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: if them 27 is marked other then "na any njury or other treumatic averages. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Hudson Myrtle Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris Goehring Daughter 2992 Normandy Drive; Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 5/18/2005 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) vice insee <sup>22</sup> Sterling Ashton Schwab Funeral Home, Inc. 101290 736 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Marigunet Physician Alex /Medical Due to (or as a consequence of): Examiner Ears Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant signed by the atter d be detached for u 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4. Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death, Check on one Hospital: Other: 1 ☐ Yes a No Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred After Natural 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number erson who completed cause of death (Item 23a) (Type, Print) Lane adr 11055 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 1 7 2005 Registrar

			1- For Amend Item 7	per fh G843	5-17-05 5-27-05	tificate of De	aith and M <i>eath</i>	ental Hyg	iene	5	16544
	Physici	an	Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month		Year	3. Time of Death
	/Media		Joseph		Gmure	K		May	15 20	25	0600 M
1	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or Lo		,	4c. County	of Death	
	Funeral		5. Social Security Number 6. Se	Bayvier Ma 7. Age (In	vrs. last birthday)	If Under 1 Year   If	f Under 24 Hrs.	8. Date of Birth	N	9 Birtho	lace (State or Foreign
	Director		212-12-9110	M 2□F	83 Yrs.	Months Days	Hours Min.	Month, Day,	1921	Cour	RYLAND
	pu *		Usual Residence of Decedent	140-	Ob. T			NOV 3	1101	1.1111	V  -1110 D
	shov	ř	10a. State 10b. County  M D B ALTI		. City, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 No
	the N	ect	10e. Street and Number	HOLE	001	OPALK 10f. Zip Code					
	d within 72 hours after death with the Maryland jene. Ir than "natural", or Itams 23a or 28e-1 show The Medical Examiner must be partitled at	Funeral Director	6926 DELVALI	E PLACE		212	77	1	0g. Citizen of W	SA	•
	death	nera	11. Marital Status	12. Was Decedent Ever i	in U.S. 13. V	Vas Decedent of Hispa Yes, specify Cuban, I		cify Yes or No-			an Indian,
9	after or Ita	/Fu	1 Never Married 2 Married	Armed Forces?  12 Yes 2 No If Yes, Give		_ \_	Mexican, Puerto I S <i>pecify:</i>	Rican, etc.)	Black	k, White,	
21215-0036	hours ural',	d by	3 Widowed 4 Divorced	Year or Dates:					Specify:	w	NITE
15	in 72 "nal	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	ent's Usual Occupatio kind of work done duri OO NOT use retired)	on ing most of workir	ng	16b. Kind of Bu	siness/Inc	lustry
212	TH 15 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	MAC		ERATO	R	WEST	ERN	ELECTRIC
	otha otha	Be C	17. Father's Name (First, Middle, Last)	^		18	B. Mother's Name	(First, Middle, A	Maiden Surname	ө)	
ylaı		To	LUKASZ	GMUREK	ζ		JOSE	PHINE	FIA	LKC	SWSKI
Maryland	and and sum		19a. Informant's Name/Relationship (T	,,, ,, ,, ,,		g Address (Street and	Number or Rura	l Route Number,	City or Town, S	State, Zip	Code)
	1 and 2 Health am 27 l		REGINA GMURE  20a. Method of Disposition		692						SSSIS OF
Jor	ages nt of h		1 Burial 2 ☐ Cremation 3 ☐ I			sition (Name of latory or other place)			20c. Location - (	•	
Baltimore,	permit. Pages: Department of H Important: If its eny injury or ot		<ul><li>4 □ Donation 5 □ Other (Specify,</li><li>21. Signature of Funeral Service Licens</li></ul>		ST. STAN	Name and Address	15119	105	DALT	more	E, MO
<b>B</b> a	Depa Impo eny i		Men	Day	122	Maine and Address o	OF ACHINKAC	zorow	Stri Fun	VERAL	Littome, P.A.
			23a. Part1. Enter the disease, or comp	lications that caused the d	leath. Do not ente	r the mode of dying, s	such as cardiac or	r respiratory arre	st,	in	Approximate
	Physician .		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.							Interval Between Onset and Death
	/Medical		resulting in death)	a. respirator	sequence of):	resi			-		
	Examiner		Sequentially list conditions,	acute (	renal f	ailure					
	ed sit	iner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of);						
•	and and al-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):					-	
09/89	sician buria	alE			004001100 017.					- 1	
89	tificate be executed g physician and as the burial-transit	edical		J							
Вох			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date	of delive	ry
ю. В	a death	sicla	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Mon	th I	Day Year
Р.	that the death cert ed by the attendin detached for use	Physiclan/N	9 Unknown								
JS,	es pe	by	Part II. Other significant conditions co	itributing to death but not	resulting in the un	derlying cause given in	n Part I.		\ .		e cause of death?
Ö	v requir been s should	etec	melanoma					1  Ye		3   Proba	ably 4 Unknown
Vital Records,	has has ge 2 :	Completed						24a. Was an autopsy perform	pr	ere autop ior to com ath?	sy findings available apletion of cause of
	iician: Th certificate rector, pag	် မေ	25. Was case referred to medical					1□ Yes 2	1 No	Yes -	2 No
	Physician: r this certific ral director,	0 0	examiner?	Hospital: 1 Inpatient 2	P☐ ER/Outpatient	04	<ol> <li>Place of Death</li> <li>Nursing Hom</li> </ol>			. (0	
o L	ding Phys	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time of	28c. Injury at		Bd. Describe how			
Sio	andir eath. or: Af he fu	atlo	1 Natural 5 Pending investigation	(World, Day 7 day	) Injury	Work? M 1 ☐ Yes	2 🗆 No				
Division	or Attanater deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, office	2	Bf. Location (Str. City or Town,	eet and Number State)	r or Rural	Route Number,
	pital ours a erel [		29a. Certifier 1 Certifying Phys	1							
	24 hc 24 hc a Fun etely	edical	(Check only one)	sicien: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or inve	occurred at the time, destigation, in my opinio	date and place, ar on, death occurre	nd due to the car d at the time, da	use(s) and man te and place, ar	ner as sta nd due to	ited. the cause(s)
	To the Hospital or Attanding Physician: The within 24 hours after death.  To tha Funerel Director: After this certificate in completely filled in by the funeral director, page	Me	29b. Signature and title of certifier			29c. License nui	mber	29	d. Date signed	(Month, D	Pay, Year)
					40	RES - 0	202	_	lav 1		
10	Und	2	30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type, P	rint)				1	2005
U			JENNA GOLDBE	eg, m.D. 49	40 EAS	TERN AU	E. BA	LTIMOR	E, MD	2	4521
• 7	Stat Registra	e ar	31. Date filed (Month, Day, Year)	2005 Ag	gnature	Sporte					

			1 - State of Ma	•	epartment of F Dertificate of		Mental Hy	giene Reg. No:	05	16545
	Physici	an	Decedent's Name (First, Middle, Last)     EDWIN GINYARD				2. Date of De		Year	3. Time of Death
	/Medio	cal	4a. Facility Name (If not institution, give street and number)	1 1	4b_City, Town, o	or Location of Death	11/My	4c. Count	by of Death	12-14
	Exami	iei	Maryland Greneral	Gospita	l Baltin	nore C	144	N	I/A	
	Funeral		1₹IM 2∏F	e (In yrs. last birth	day) If Under 1 Year Months Days	Hours Min.	8. Date of Bi	th ay, Year)	Cou	place (State or Foreign intry)
	Director		Usual Residence of Decedent	58'			4-8-1	947		RYLAND
	ith the Marylan or 28a-1 show	5	10a. State 10b. County MD • N/A	10c. City, Town BALT						10d. Inside City Limits 1 □XYes 2 □ No
	the M 28a-1	Funeral Director	10e. Street and Number	DITE!	10f. Zip Code			10g. Citizen of	What Cou	
	h with 23a or	ai Di	2042 N. FULTON AVE.		2121	7		USA		
	er death w Items 23a	uner	11. Marital Status 12. Was Decedent Armed Forces?		13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No Rican, etc.)		ice - Ameri ack, White,	ican Indian, , etc.
0036	urs afte	þ	1 Never Married	No	1 ☐ Yes ZX No	Specify:		Speci	ity: BLA	ACK
20-5	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-1 show event, it.e M. Jical Exs. rift or mast be notified at	Be Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occup Give kind of work done	during most of work	king	16b. Kind of 8	3usiness/Ir	ndustry
25	within ene. than	ompi	Elementary/Secondary (0-12) College (1-4or 5	5+)	life. DO NOT use retire ORKLIFT OPE			DENCO	COPT	PORATION
\(\sigma\) \(\frac{1}{2}\)	e filed al Hygi other vent, I	se Co	17. Father's Name (First, Middle, Last)		KKLIFI OFE	18. Mother's Nam		, Maiden Suma	me)	ORATION
yar	2 should be filed within and Mental Hygiene. Is marked othar than aumatic event, I.e.M.	To E	JAMES GINYARD					HINGTON		
Mar	d 2 sh th and th and traum		19a. Informant's Name/Relationship (Type, Print)  VERNE GINYARD (WIFE)		Mailing Address (Street  142 N. FULT					,
re,	Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.  Moortant: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Item 2012.		20a. Method of Disposition		Disposition (Name of , crematory or other pla		Date 0-2005	20c. Location		
3 iii	Pages ment of lant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)	GARRIS	N FOREST V	ETERANS				S, MARYLAND
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fineral Service Livens JONATHAN	D. HIB					-	
			23a. Part Enter the disease, or complications that caused	the death. Do no	·				PIAKI	ZLAND 21217 Approximate Interval Between
	Pnysician		shock, or heart failure. List only one sause on each li Immediate Cause (Final disease or condition	threy.	Failure					Onset and Death
	/Medical Examiner		reculting in death)	a construence o	i):					
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as	a consequence o	umonia		. 1			
	ecuted and I-transit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cano		tage 4	7			
60,	be exician	ai Ex	resulting in death) Last Due to Lot as	a consequence o	i):					
687	cate phys	edicai	d							
Вох	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth	of pregnancy 2 Petal death	3 □Ectopic pregnanc	;y			ate of deliv	/ery Day Year
P.O. E	that the deathed by the atte	ysici	in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  4 □ Pregnant a 9 □ Unknown	t time of death	5 ☐ Other (specify) _				Ontai	Day Four
	Hospital or Attending Physician: The law requires that the death certifi 24 hours atter death. Funeral Director: After this certificate has been signed by the attending. tely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions contributing to death b	ut not resulting in		1		tobacco use cor	ntribute to f	the cause of death?
ords	w require been sig should b	ted k	HEPATIC CANCER	WIT	XAIN N	/(ETHST	ASU 10	Yes 2□No	3 ☐ Pro	
of Vital Records,	e taw r has be je 2 sh	mpie	HYPERTENSION		<u> </u>		24a. Was	san 24b. psy ormed#2	Were auto prior to co death?	opsy findings available ompletion of cause of
talF	ician: The I certificate he ector, page		25. Was case referred to medical			26. Place of Dea		2 No	1 🗆 Yes	2□ No
<u> </u>	nysician: nis certific director,	To Be	examiner?  Yes 2 □ No  Hospital: 1 □ Inpatie	ent 2 ER/Out	patient 3 DOA	her		idence 6 🗆 Ot	ther (Speci	ify)
	ding Ph h, After th funeral	lon:	27. nanner of Death 28a. Date of Inju Natural 5 ☐ Pending (Month, Da	y Year) 28b. Ti	jury Wo	iry at ork? ] Yes 2 □ No	28d. Describe	how injury occu	rred	
Division	Attendi death, octor: A	ficat	Accident investigation  3 Suicide 6 Could not be determined 28e. Place of In	ury - At home, far	m, street, factory, office		28f. Location	(Street and Num	aber or Rui	ral Route Number,
Ο̈́	ipital or At ours after o eral Direc filled in by	Certification:	4 Homicide determined building, et	c. (Specify)			City or 10	wn, State)		
	To the Hospital or Attenwithin 24 hours after deat To the Euneral Director: completely filled in by the	edicai	29a. Certifier (Check only one)  Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and	death occurred at the to for investigation, in my	ime, date and place opinion, death occur	, and due to the rred at the time	cause(s) and m date and place	anner as s , and due (	stated. to the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier		29c. Licen	se number		29d. Date sign	ed (Month,	, Day, Year)
	VI		X Cam frazie		2 89	1543		5/1.	3105	, j
	107		30. Name and address of person who completed cause of a	death (Item 23a) (	Marylan	d Gen	eral	HOSD	11 ta	il
		ate	31. Date filed (Month, Day, Year) 32. Registr	rar's Signature	carles			-		
	Regist	rar	MAY I Y CORD YEAR	- 17						

			Sta	te of Marylar					9	
			1 - For State Registrar	te or iviarytar		rtificate of L			2000	16516
			Decedent's Name (First, Middle, Last)			timodic of L	- Calif	2. Date of Death	g.No.UUJ	3. Time of Death
	Physici		ETTO. 1 (:11.					Month	Day Year	11-15-6 M
	/Medic Examin		4a. Facility Name (If not institution, give street a	nd number)		4b. City, Town, or	Location of Death	may	4c. County of Deatl	n 43/5
			Northwest Ho	m. 401		Pantal	istown		Balt:	(es 1) D. O.
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	JAN. I, 19	Y.ear) 9. Birtl	nplace (State or Foreign
	Director		215-01-4792 1X M 2		89 Yrs.			JAN. 1, 19	16	MD
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Many a-fsh	tor	MD BALTIMOR	E	OWING	S MILLS				1 ☐ Yes 2 🔀 No
	th the or 284 e.not	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	ath wi	Funeral Director	4730 ATRIUM COURT #6	10			21117			USA
	er deg	une	11. Marital Status 12. Wa.	s Decedent Ever in U ned Forces?	J.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs aft	by F	_ If Ŷ	Yes 2 ☐ No es, Give ar or Dates:		1 ☐ Yes 2 🏹 No	Specify:		Specify:	WHITE
21215-0036	2 hou	ted	15. Decedent's Education		16a. Dece	dent's Usual Occupa	ition	11	6b. Kind of Business/l	ndustry
215	hin 7: 9. 9. "P	ple	(Specify only highest grade comp.  Elementary/Secondary (0-12) Coll	lege (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	uring most of work	ting		
	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or items 23e or 28e-f show int, fre Madical Examiner must be notified at	Completed	4		CERTIF	FIED PUBL	IC ACCOUN	TANT	ACCOUNTING	1
nd	be fit ital H id oth	Be	17. Father's Name (First, Middle, Last)		07113			e (First, Middle, M	aiden Sumame)	FORMAN
3	should nd Mer marke umetic	<sup>2</sup>	JOSEPH	-41	GILLI		LENA	-10 11	0 7	FORMAN
Maryland	S a 8		19a. Informant's Name/Relationship (Type, Prir LILLIAN G. GILLIS /	-					City or Town, State, Z S MILLS, M	
	s 1 and f Health item 27 other ti		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of			Oc. Location - City or	
Ë	Pages nent of int: If it		1   Burial 2 □ Cremation 3 □ Removal  Contains 5 □ Other (Specify)	from State	•	natory`or other place DUNG MEN (	· .	15/2005	WOODLAWN,	MD
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licenses	11)		2. Name and Addres	-		N & BROS.,	
<u> </u>	89 = 28		Death 11/ little	th	89	000 REIST			KESVILLE,	
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the deat e on each line.	th. Do not ent	er the mode of dying	, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Dhenn	oria					Onset and Death
	/Medical Examiner		D D	e to (or as a consec	quence of):					
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	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events c.							
ó	uires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	Exa	requisite in death Leas	ue to (or as a consec	quence of):					
8760,		lical	d.							
x 68	ertific ding p	/Mec	IF FEMALE:							
Bo	attend for us	ian,	in the past 12 months?	es, outcome of pregna Live birth 2 Feta Pregnant at time of c	al death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
P.O. Box	the du y the sched	Physician/Med		Unknown	10a(ii )_	JOHIBI (Specify)				
	Attanding Physicien: The law requires that the death certifica reach. r death. ector: Atter this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	by Pi	Part II. Other significant conditions contributing	g to death but not res	sulting in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ğ	w require been sig should b							1 ☐ Yes	2 1 No 3 □ Pro	obably 4 Unknown
Records,	law requas been 2 should	Completed						24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
<u>س</u>	The law cate has page 2:	Con						performe 1 □ Yes 21	ed?   death?	2 No
Vita	Physicien: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:			0.4.		h (Check only one		335
ot	Phys r this ral dii	2	To res Zurno	1 1 Inpatient 2 □ Dat of Injury	ER/Outpatien 28b. Time of		4 Nursing Ho	ome 5 Residen 28d. Describe how	ce 6 Other (Spec	sify)
Division of	iding Phy th. : After thi s funeral	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	? ′es 2 □ No	200. 2030.120 1104	vinjury occurred	
VISI	Atter r dea ector by the	ifica	3 □ Suicido 6 □ Could not be	Place of Injury - At h		eet, factory, office			et and Number or Ru	ral Route Number,
	s after s afte	Certification;	4   Horricas	building, etc. (Specif	(Y)			City or Town,	State)	
	Hospital or Attend 14 hours after death Funerel Director: tely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: On	To the best of my kno	owledge, death	occurred at the time	e, date and place,	and due to the cau	use(s) and manner as	stated.
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Med	one) and 29b. Signature and title of certifier	i manner stated.						
	To Yit	-	255. Signature and this of certifier	1		29c. License	,297/	,	d. Date signed (Month	
	0		30. Name and address of person who completed	cause of death (Iton	n 23a) /Type	17 9 Print)	7 / / 6	t hi	ay 15	2006
1	,		Alia I-Is L	> > A	J- /-	losn: ta	1 Pr	101100	Dun he	ary land
	Sta	. 9	31. Date filed (Month, Day, Year)	32. Jegistrar's Signa	A.	Print)		4-1-11/11/	1100	
	Registra	ar	MAITION	14 Paris						

			1- State Regist <b>amend item</b>				artment of H		nd Mer		giene ()	5	16547
	Physic		1. Decedent's Name (First, Middle	Last)	_	HARR				Date of Dea Month		/ear	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution,		r)	oital	4b. City, Town, or Bel 1.T		Death		4c. County of		
	Funeral Director				11 40	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8.	Date of Birth Month, Day 2 24	, Year)	Coun	ace (State or Foreign try) MD
	land SW		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					11	Od. Inside City Limits
	with the Maryland a or 28a-f show Lb. notified at	tor	MD NA		Ва	ltimo	re						1 Ves 2 □ No
	or 28s	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of Wh	at Coun	try?
	death w		4042 West Col					215			U.S.		
36	after or ita	by Funerai	11. Marital Status  1 □ Never Married X□XMarrie  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces ed 1 Yes 2 If If Yes, Give Year or Dates	6? ]No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin n, Mexican, P Specify:	i? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race Black,	White, e	
215-0036	72 hours "natural", adical Exa		15. Decedent' (Specify only highesi	s Education		16a. Dece	ient's Usual Occupa	ation	fadda		16b. Kind of Busi		
121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)		kind of work done of DO NOT use retired	uring most of	working				
d 21	filed v Hygie other t	e Co	12th grade 17. Father's Name (First, Middle, L	na _ast)			Owner	18. Mother's	Name (Fir	st Middle I	Janit Maiden Surname)		al Servic
Maryland	should ba filed withir nd Mental Hygiene. markad other than matic event, tha M	To Be	Obie Harris S					Leah			valuen cumume)		
lary	2 short and h is ma		19a. Informant's Name/Relationsh			4	g Address (Street a	and Number o	or Rural Ro	ute Number			
	es 1 and 2 st of Health and fitem 27 is n r other traun		Patricia Harr 20a. Method of Disposition	is-Wife	20h P		West Co	oldspi	ring				Md 21215
nor			1 Donation 5 □ Other (Sp		e C	emetery, crer	natory or other place	1			20c. Location - C	•	
Baltimore,	parmit. Page Department o Important: If any injury or once.		21. Signature of Fune at Service L		) KI		morial l Name and Addres arch F/l			/05	Randa1	IST	own, Md
	202 0 0		23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that ausi	Meg	4	<u>300 Waba</u>	ash Av	ve, 1			Мd	21215 Approximate
	Physician	0.4	Immediate Cause (Final									2-	Interval Between Onset and Death
8	/Medical		disease or condition resulting in death)	aDue to (or a			nyocar	OGOL	_ +	1116	206116	ML	MICH DISH
	Examiner		Sequentially list conditions,	b									
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8760,	icate be executed physician and the burial-transit	dicai	,	d									
9	ding p	ω ⊦	IF FEMALE:	23c If was outcom	o of progna	n							
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)				23d. Date of Month		y Day Year
s, P.	es that igned b	by P	Part II. Other significant condition	s contributing to death	but not resu	ulting in the u	nderlying cause give	n in Part I.		23e. Did tob	acco use contrib	ute to the	cause of death?
ord	w require been sig should b	ted								1 🗌 Ye	es 2□No 3	☐ Proba	bly 4 Unknown
Il Record		Completed								24a. Was ar autops perform	y prid	re autop or to com th? Yes	sy findings available interior of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0#10	26. Place of	Death (Ch	eck only on	e)		
of	Phys ral di	٥.	1 Yes 2 No	1 ☐ Inpat		28b. Time of	3 DOA Othe	4			nce 6 Other		
ion	utending F death. ctor: After y the funera	ation	1 Natural 5 Pending 2 Accident investiga	(Month, D	ay Year)	Injury	Work	? es 2 □ No			,,		
Division	ira de	Certification:	3 Suicide 6 Could no determin	and 286. Place of Ir	ijury - At ho tc. (Specify	me, farm, str	eet, factory, office		28f. L	ocation (Sti City or Town	reet and Number , State)	or Rural	Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bes xaminer: On the basis and manner s	or examınar	wledge, death ion and/or inv	occurred at the time estigation, in my op	e, date and pl inion, death o	lace, and o	ue to the ca the time, da	use(s) and mann ate and place, and	er as sta	ited. the cause(s)
	To t To t com	Σ	29b. Signature and title of certifier				29c. License				9d. Date signed (i		
,	. *	-	Sophen	1. (to)	5	m.D	Doc	42	65	8 /	MAY S	5,2	005
	10	1	30. Name and address of person w		death (Item	23a) (Type,	Print)	Deir	1 B	0:1	6	01	005 rinere
	Sta Registr	е	31. Date filed (Month, Day, Year)	32 Regist	rar's Signat	ture Apr	20011	TO CE	1 0	C: V8 ( 9	C Corel		
	negistr	41 s	MAY 1.7	ZUUD SIEGE	20	1400	and the same of th						

			For	State of					ilth and M	•		_	e.	
			1 - State Registrar			C	ertificate	of De	ath		Reg. N	200	5	16548
	Dhugi	ion	1. Decedent's Name (First, Middle, La	st)						2. Date of D Month	eath Da	av Y	ear	3. Time of Death
	Physic /Med		Parthenia Regina							May 16	_	005		6:50 AM M
	Exam	iner	4a. Facility Name (If not institution, giv				4b. City, 1	Fown, or Loc	cation of Death			c. County of		
			Gilchrist Center				(v) If Under		WSON Under 24 Hrs.	0 Date of B		altimo		(Chat
	Funera		5. Social Security Number 6. S 577-58-3581	M 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (in yr	s. last birthda Yrs.	Months		lours Min.	8. Date of Bi (Month, D				ce (State or Foreign
	Directo	4	Usual Residence of Decedent		02					02/07	/194	3 DC		
1.0	yland		10a. State 10b. County		10c. (	City, Town or	Location						100	f. Inside City Limits
00	Mar	to	MD Howard		Co	lumbia	ı							1 ☐ Yes 2 No
Jay 16,200	036 $000$	Completed by Funeral Director	10e. Street and Number				10f. Zip	Code			10g. C	itizen of Wha	at Country	y?
9	23a vi	a	5737 Twelve Month	Court			210	44			Uni	ted S	tates	s
7	r dea	Iner	11. Marital Status	Armed Fo	edent Ever in	U.S. 13	<ol> <li>Was Deced If Yes, spec</li> </ol>	ent of Hispa ify Cuban, M	nic Origin? (Speedexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black,	American White, et	
3	36 afte	Y.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes If Yes, Gi Year or D	2 No ve		1 ☐ Yes 2	No S	pecify:			Specify:		
-	O E 5 1	d b	3 StVidowed 4 □ Divorced		Dates:	16a Da	andantia I lava	I Occupation			105	Kind of Busin	lack	
(1)	15-	jete	15. Decedent's E (Specify only highest gra	ade completed)		(Gir	cedent's Usua ive kind of wor a. DO NOT us	k done durin e retired)	ng most of work	ing		Lf Emp		•
37	V12	l mc	Elementary/Secondary (0-12)	College (	1-4or 5+)		Care P				261	rr Emp	толе	u
7	Hyginther ant, 1		17. Father's Name (First, Middle, Last	)	2	Day	care r		. Mother's Name	e (First, Middle	e, <i>Maid</i> e	n Sumame)		
	E dab ≥	To Be	Joseph Nathan Gre	en				E	mma Par	thenia	Monr	o e		
A	Marylar d 2 should be th and Menta th and Menta th and marked traumatic st	-	19a. Informant's Name/Relationship (			19b. Ma	ailing Address	(Street and	Number or Run	al Route Numi	ber, City	or Town, St.	ate, Zip C	'ode)
ARTHENIA	Magarita 27 it		Wendy Mahoney /Dau	ighter		691	1 Bante	er Roa	d Hyatt	sville	, ME	2078	4	
F	Baltimore, permit. Pages 1 at Department of Heal Important: If item any injury or other and injury or othe		20a. Method of Disposition		20b	. Place of Dis	sposition (Namerematory or ot	ne of ther place)	1	Date	20c. l	ocation - Ci	ty or Tow	n, State
RI	Pages nent of h		1 ☐ Burial 2 ② Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special		State		ake Cre			May 19 2005	Bel	tsvill	e, Ma	aryland
04	Baltimo		21. Signature of Funeral Service Lice	1500	140098	(,	22. Name and	d Address of	f Facility					
	<b>a</b> 33558		Hah	u			8717 Gr	een Pa	d Funera astures	Drive	Balt		Mary	yland
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that	caused the de each line.	ath. Do not e	enter the mode	of dying, su	uch as cardiac	or respiratory	arrest,		- 11	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	400-			cane						· ·	Onset and Death
	/Medica		resulting in death)		(or as a cons		<u> </u>					, , <del>, , , , , , , , , , , , , , , , , </del>		G-11/A
	Examine		Sequentially list conditions.	b										
	De #s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a cons	equence of):								
	760, e be executed rsicien and be burial-transit	хап	that initiated events resulting in death) Last	c	(or as a cons	equence of):								
	760, te be ex ysicien a	calE			(	- 1								
	S87 icate phys	dic		d										
	Box 68760, eath certificate be executed attending physicien and for use as the buriat-transit	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou								23d. Date of	of delivery	,
	BC leath atter	ciar	in the past 12 months?		birth 2□Fe nant at time o		3 □Ectopic pro 5 □ Othe <i>r (sp</i> o	egnancy ecify)				Month	,	ay Year
	hat the deed by the a	hysi	9 Unknown	9□ Unkn	iown									
	Division of Vital Records, P.O. to Attending Physician: The law requires that the datter death.  Director: After this certificate has been signed by the tine by the funeral director, page 2 should be detached.	by Physician/Medi	Part II. Other significant conditions	contributing to d	leath but not r	esulting in the	e underlying ca	ause given ir	n Part I.	23e. Did	tobacco	use contrib	ute to the	cause of death?
	cords w require been sig									1 🗆	Yes :	2 □ No 3	Probab	oly 4 nknown
	as be	piet								24a. Wa	s an	24b. We	re autops	y findings available
	The I	Completed									formed?	dea	th? Yes 2	
	f Vital F ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26	. Place of Deat	h (Check only				
	Of V Physic this ce al dire	10	1 ☐ Yes 2 X No	Hospital: 1 🗆	Inpatient 2	☐ ER/Outpat	tient 3 DO	A Other:	4 Nursing Ho	me 5 Res	sidence	6 Other	(Specify)	Hospice
	on of ding Phy h. After thi funeral of	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time	у	Bc. Injury at Work?		28d. Describe	how inj	ury occurred		
	isiol Mtendii death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М		2 No		(0)			
	Division attendated after death Director.	Certification:	4 Homicide determined	286. Place	e of Injury - Al ling, etc. <i>(Spe</i>	t home, farm, cify)	street, factory	, office		City or To			or Rural F	Route Number,
	pital pital aurs a serai E		29a. Certifier Certifying Pl	tunicina. To th	a bast of much	racional de la de	ath assured	at the time .	date and place	and due to the		s) and man		
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Exa	nysician: To the miner: On the b and man	asis of exami ner stated.	ination and/or	investigation,	in my opinic	on, death occur	red at the time	, date a	nd place, and	d due to th	ed. ne cause(s)
	o the o the	Me	29b. Signature and title of certifier	0	mor otatoa.		29c	. License nu	ımber		29d. D	ate signed (	Month, Da	ay, Year)
	F ≤ F ö		MI I MAN	1 m	~			D28.	303		MA	4 16	200	5
	7 0, a		30. Name and address of person who	completed cau	se of death (I	tem 23a) (Tvo	oe, Print)			6601 N	. Ch	arles	Stre	et
	10			esmo	)	, ()P	,			Towson				
	S	tate	31. Date filed (Month, Day, Year)	32.	gistrar's Sig	nature	(ports)	,						
	Regis	trar	MAY 17	2005	Pollets.	Ar 1	1							

DHMH 17 Rev 1/2001

			1 - For Stata Ragistrar	State of Maryl		artment of ertificate o				giene Reg. No.	005	16549
	Physici /Medic Examir	cal	4a. Facility Name (If not institution,	fansen	1 caled	4b. City, Town	n, or Location	n of Death	2. Date of Dea Month	Day 4c. (	Year 200 County of Dea	th
	Funeral Director		1		yrs. last birthday		ar If Und	er 24 Hrs.	8. Date of Birth (Month, Day 09/17	h /, Year)	9. Bir	thplace (State or Foreign buntry)
	he Maryland 28a-f show criffed at	Director	MD Baltin		. City, Town or L					40- Cisis	and of Milant O	10d. Inside City Limits
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural" or Items 23a or 28a-f ehow other than "natural" or Items 23a or 28a-f ehow event, it is Medical Examinational by notified at	by Funeral Dir	9 Crafton Road  11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	in U.S. 13.	10f. Zip Cod 21221 Was Decedent of Yes, specify C	L of Hispanic cuban, Mexic	can, Puerto P	cify Yes or No-	Unit	ted Sta  14. Race - Ame Black, White  Specify: Wh:	ites erican Indian,
9500-61212	filed within 72 hours aff Hygiene. other than "natural", or ent, Itis Medical Exam	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Giv life.	edent's Usual Oc e kind of work do DO NOT use re mbler	ne during m tired)			Luml	nd of Business ber	
Maryland	m = 0 %	To Be	17. Father's Name (First, Middle, La Martin Conrad Ha 19a. Informant's Name/Relationshi	ansen p (Type, Print)	19b. Mai	ling Address (Str.	Lo	is Ruth	(First, Middle, Yeager Route Numbe			Zip Code)
altimore, M	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic and once.		Mary Ash / Sister  20a. Method of Disposition  1	20 B □Removal from State	b. Place of Disp cemetery, cre	rafton R position (Name of ematory or other make Crem	place)	D:	ate May 14	20c. Loc	cation - City or	Town, State
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Li	censee Mor	0986	22. Name and Ad Cremation 8717 Gree	dress of Fa n and en Pas	cility Funera tures_l	l Alteri Drive l	Balti		Maryland 21286
8760,	certificate be executed // Medical physician and itse as the burial-transit	Ical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. End stage Due to (or as a con	resequence of):  Liver resequence of):	Disease	entor holism	N. (1) 11 - 12 - 12 - 12 - 12 - 12 - 12 - 12		and the sec		Approximate Interval Between Onset and Death
O. Box 68	death e atter d for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregna □ Other (specify				2	23d. Date of de Month	livery Day Year
ecords, P.	The law requires that the ten be been signed by thoses 2 should be detache	by	Part II. Other significant condition	s contributing to death but not	t resulting in the	underlying cause	given in Pa	rt I.		obacco us	□No 3□P	o the cause of death? robably 4 Unknown
Y		e Completed	25. Was case referred to medical				26. Pl	ace of Death	24a. Was autop perfor 1 Yes	rmed? 2 No	24b. Were a prior to death?	utopsy findings available completion of cause of
Division of Vi	ding l	ation: To B	examiner?  1 Yes 2 No  27. Manner of Death    Xiatural 5 Pending investiga	28a. Date Injury (Month, Day Yea	2 ER/Outpation 28b. Time Injury	of 28c. I		Nursing Hon	ne 5 🗆 Resid	dence 6		ecify)
DIVIS	oital or Atteurs after de oral Directo	Certification:	3 Suicide 6 Could no 4 Homicide determin	building, etc. (Sp.	pecify)				City or Tow	vn, State)	)	lural Route Number,
	To the Hospital or Attent within 24 hours after deati To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical E one)  29b. Signature and fitle of certifier  S. Yuang K	Physician: To the best of my xaminer: On the basis of exam and manner stated.	mination and/or i	nvestigation, in n	ny opinion, o ense numbe	death occurre	ed at the time,	date and 29d. Date	e signed (Mon	th, Day, Year)
	1		30. Name and address of person w S. Shane Kon	4	(Item 23a) (Type Johns	Hopkin	s Ba	yvien	Medi	ca(	Certe	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's S	signature	wester						

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 04:00 a M William . 2005 Bruce Harmis May 8. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Linthicum Hospice of Chesapeake | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 24, 1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Months 218-05-9968 84 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Musical Experiment has be notified at 1 Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1109 McHenry Drive 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 TYPES 2 No 1941 If Yes, Give Year or Dates: 1945 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 Caucasian Specify: Specify: Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. int: If Item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Blender Liquor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Walter F. Harmis Laura Beatrice Tucker 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Shenton 309 Shipley Ave. Glen Burnie, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Durial 2 □ Cremetion 3 Removal from State ō permit. Page Department of Importent: If any injury or once. Loudon Park Cemetery 05/12/2005 Baltimore 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Fune all Terrice Licens 3620 Wilkens Ave. Baltimore, MD 21229 Approximate Interval Between Onset and Death Park: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): the attending physician Completed by Physician/Medical as the use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ٥ Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached P.O. 9 Unknown 9 Unknown δ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 9 2 0 3 Probably 4 Unknown 1 Tes peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Phyaicien: completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division To the Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Yoar) 29b. Signature and title of certifier 29c. License number 2005 who completed cause of death (Item 23a) (Type, Print) 2106 WD State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

M					ok indelible ink. Ensure A		_	
			1 - State Unpend Item Registramend item  1. Decedent's Name (First, Middle, La	#19b per fh 2843	Department of Health and I me G845 7-28-05 tas 5720705 atent Death	Reg		16551
	Physici		Norma F. H	Jandy-Wos	+	2. Date of Death MAY 11,	2005 Year	3. Time of Death 4:56 P M
	/Medi Examir		4a. Facility Name (If not institution, given	re street and number)	4b. City, Town, or Location of Death		4c. County of Death	7.50 1
			2085 REESE RD		WESTMINSTER		CARROLL (	
	Funeral Director			Sex 7. Age (In yrs. last bi	hthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthing	place (State or Foreign htry)
()	anyland show		10a. State 10b. County	10c. City, Tow	m or Location		1	10d. Inside City Limits
	Ba-1 st	Director	Maryland Carr	oll We:	stminster			1 Yes 2 □ No
	3e or 2		10e. Street and Number	co DI	10f. Zip Code	10g	Citizen of What Cour	ntry?
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerti	pecify Yes or No-	14. Race - Americ	can Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural; or Items 23e or 28e-1 show other traumatic event, if it is Madical Examinational be rediffied at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🌠 No Specify:	o nican, etc.)	Black, White,	etc.
21215-0036	2 hour	ted t	15. Decedent's E	ducation 16a	. Decedent's Usual Occupation	16	b. Kind of Business/In	dustry
215	ithin 7 ne. nen "n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	king	1001	
	Hygier Hygier Ther th		17. Father's Name (First, Middle, Lasi	2 1	Postmaster 18 Mathada Nan	ne (First, Middle, Ma	15, Posta	Service
land	ld be f ental f ked of	o Be	Frnest N	Cov.	Love		Johns	0n
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, It e.M.	-	19a. Informant's Name/Relationship	Type, Print) (Husband) 19t	p. Mailing Address (Street and Number or Ru			
_	무를 2 :		Mr. tred Wes	st /2	085 Keese R	d. Balt	o. Mel.	
Jore	Pages 1 nent of H ont: If Ite		20a. Method of Disposition  1 ☐ Burial 2 ▼ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Speci	Removal from State cemete	f Disposition (Name of rry, crematory or other place)	Date 20	c. Location - City or To	Own, State
Baltimore,	그 든 뿐 글		* 4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice	MILE	22. Name and Address of Fallity	112005	Salto.	IVIA.
m	Departiment from the second se		Joseph	L. Buss	Joseph L. Kuss h	ineral l	tome 1212	16
				plications that caused the death. Do one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Contact gunshot  Due to (or as a consequence				
п	Examiner		Comments the time and divine	bue to (or as a consequence	or).			
	pe jis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Day to for as a consequence	of):			
	te be executed ysician and ie burial-transit	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a consequence	of):			
120	ate be nysicia he buri	cal		d				
89 x	leath certificate attending phy ifor use as the	Physician/Medi	IF FEMALE:	22a Kusa subsema of second	- Tallin			
Вох	attend I for us	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
P.O.	at the de by the a tached	hysl	1 ☐ Yes 2 ☐ No 9 € Unknown	9□ Unknown				
	res tha signed I be det	by	Part II. Other significant conditions	contributing to death but not resulting i	n the underlying cause given in Part I.		co use contribute to the	
Sorc	w requir been si should	leted				1 ☐ Yes 24a. Was an	7	ably 4 Unknown
Vital Records,	The lay	Completed				autopsy performed	d? prior to co	psy findings available mpletion of cause of
/ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		26. Place of Dea	th Check onl one	1140 72 143	2 110
of \	Phyai this c	. To	1 XYes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/O		ome 5 Residence	e Other (Specificial)	y) SCENE
on	ding F th. : After s funera	tlon	1 □ Natural 5 □ Pending 2 □ Accident investigation	5-140nth Day Year) 4:1	mury Work?	subject sl		
Division of	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 ☐ Could not be determined	OB Discontinuo Athana		28f. Location (Stree City or Town, S	at and Number or Rura State) 2085 Rec	Il Route Number,
	spital or At ours after o nerel Direc filled in by	Cer		found at home		Westminste	er, Maryla	nd
	24 h	edical	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 🔀 Medical Exa	nysician: To the best of my knowledgeminer: On the basis of examination ar and manner stated.	e, death occurred at the time, date and place d/or investigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as si and place, and due to	tated. the cause(s)
	To the	Me	29b. Signature and title of certifier	1 0	29c. License number		Date signed (Month,	
	an is		Jastal	hearlier M	OCME	M	AY 12, 200	5
	209		30. Name and address of pers who	completed cause of death (Item 23a)	(Type, Print) 111 Penn Street	Baltimore	e. Marvlan	1 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra's Signature	barker .		-, rary ran	4 414VI
	Registr	ar	MAY 1 7 200	5 Blesmes St. A				

			State of Maryland		artment of H			ene 00	16552
	Physici	an	1. Decedent's Name (First, Middle, Last)  Richard David Hough, Sr.				2. Date of Death	1	ar 1055 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		_	Location of Death	,	4c. County of E	
	Funeral		Good Samaritan Hospital  5. Social Security Number  6. Sex 11 M 2 F		Baltimore If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	N/A Year) 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	Yrs.			Dec. 9	, 1943	VA
	Marylan f show	ţo	, , , , , , , , , , , , , , , , , , , ,	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	with the	Director	10e. Street and Number		10f. Zip Code 212	27	10	og. Citizen of What	t Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant. It is Medical Examiner must be notified at once.	by Funeral	2420 E11is Road  11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced  12. Was Decedent Ever in U.S Armed Forces? 1  Yes 2 Mo If Yes, Give Year or Dates:			ispanic Origin? (Spe in, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - A	American Indian, White, etc. White
Baltimore, Maryland 21215-0036	within 72 hour sne. than "natural" e Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  N/A	(Ĝive life.	dent's Usual Occup kind of work done o DO NOT use retired	during most of worki i)	ing	16b. Kind of Busine	ess/Industry
and 2	id be filed vental Hygie ked other ic	To Be Co	17. Father's Name (First, Middle, Last)  Robert David Hough	0100		18. Mother's Name	(First, Middle, N	Meiden Sumame)	
Mary	12 shoul	ř	19a. Informant's Name/Relationship (Type, Print)			and Number or Rura			te, Zip Code)
more, I	Pages 1 and ent of Health nt: If Item 27 ry or other t		1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State BaT	ace of Dispo	osition (Name of matory or other place e Washing	! 1	Date 2	Laure1,	
Baltiı	permit. F Departmo Importar any injur		21. Signature of Funeral Service Divensee  Michael J. Flag	L L	2. Name and Addrese emmon Fun		of Dula	aney Vali	ley, Inc.
	Physician		23a. Part Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition as the cause on each line.	Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of the conditions of	ence of):	7 - 1 - 0 - 7 10	7112 000	17 030		
8760,	cate be executed oblysicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cons						
P.O. Box 6	ne death certifi the attending ( hed for use as	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3(	_Ectopic pregnancy _ Other (specify) _	/		23d. Date o Month	f delivery Day Year
rds, P.	n requires that the been signed by should be detact	d by Ph	Part II. Other significant conditions contributing to death but not resu	Iting in the t	underlying cause giv	ven in Part I.			te to the cause of death?  Probably 4 Honknown
Vital Records,	The law requate has been page 2 shoul	Complete					24a. Was a autops perform	ry prio med? dea	re autopsy findings available r to completion of cause of that the second second second second res 2 \square No
Vita	ysician: The scertificate director, pag	To Be	25. Was case referred to medical examiner?  1 🗶 Yes 2 🗆 No Hospital:	ER/Outpatie	nt 3 DOA Oth	26. Place of Deat		ence 6 □Other (	(Specify)
Division of	ling After	Certification; T	27. Mann, r of Death  1	28b. Time of Injury	M 1	ry at rk?  Yes 2 □ No		ow injury occurred	or Rural Route Number,
Divi	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the incompletely filled incompletely filled in the incompletely filled in the incompletely filled incompletely f		4 ☐ Homicide determined building, etc. (Specify	·)			City or Town	n, State)	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my known and manner stated.	wledge, dea ion and/or i	nvestigation, in my o	opinion, death occur	red at the time, d	ate and place, and	I due to the cause(s)
	with Com	×	29b. Signature and title of certifier  De Shule A	w	29c. Licens	ocme		19d. Date signed (// 1ay 14, 2	
_\	0		30. Name and address of person who completed cause of death (Item  MANA A. K. K. K. C.		, Print) 111	Penn Stre	eet Bal	timore, N	Maryland 21201
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Restrar's Signa MAY 1 7 2005	J.	both				

			State of Maryland / State Registrar		rtment of Health an	nd Men		ene 005	16553
	Physici	an	1. Decedent's Name (First, Middle, Last)  Joan Marie Hamilton				Date of Death Month	Day Year	3. Time of Death 1:34 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  FRANKLIN SQUARE (HOSPIT	ral	4b. City, Town, or Location of E		(00)	4c. County of Death	
	Funeral Director		5. Social Security Number  266-72-3900  6. Sex 1 M 2 K F  60  Usual Residence of Decedent	birthday) Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min.	Date of Birth (Month, Day, arch 1.	Year) Col	nplace (State or Foreign untry) ryland
A Company of the Comp	a-f show	ctor	10a. State 10b. County 10c. City, To	own or Loc					10d. Inside City Limits  1 Yes 2 □ No
4	a or 28 be ru	Director	10e. Street and Number 3125 Belair Road		10f. Zip Code		10	g. Citizen of What Co	untry?
- 3	including the medical factors are constituted in the maryan lat Hygiene.  st other than "natural", or flems 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  Married 1 Never Married  Married	13. V	21213 Vas Decedent of Hispanic Origin Yes, specify Cuban, Mexican, F	n? (Specify Puerto Rica	Yes or No-	USA 14. Race - Ame Black, White	
21215-0036	atural', or	ò	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Sa. Deced	Yes 2X No Specify:		1	Specify: W	nite
	al Hygiene. other than "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12) College (1·4or 5+)  12	life. D	ind of work done during most of NOT use retired)	of working		Own Home	
	should be ind and Mental Hy s marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last)  Lucien Ravier			s Name (Fi		aiden Sumame)	
,	traum	6 8			g Address <i>(Street and Number o</i> Belair Road Bal				
1	nent of Health Int: If item 27 i		20a. Method of Disposition 1 Burial 2 Coremation 3 Removal from State 20b. Place ceme	of Dispos tery, crem	sition (Name of latery or other place)	Date	2	Oc. Location - City or	
	perilli. Tages i aru z sioud Doparment of Health and Men Important: If item 27 is marke any injury or other traumatic <u>once.</u>		4 □ Donation 5 □ Other (Specify) Metro  21. Signature of Funeral Service Licensee		natory Inc.   05 Name and Address of Facility remation Societ 99 Frederick Ro	5/16/( ty Of	05 I Marvla	Baltimore, and Inc.	Maryland
	705 9 9		Thomas Gregor  23a. Part 1. Enter the disease, or complications that caused the death. D	29 no not ente	99 Frederick Ro	oad Ba	altimon	ce, Maryla	ADDIOXIMATE
	nysician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence)		red by Resp	irat	oryF	aj lure	Interval Between Onset and Death
on,	ate be executed hysician and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence cause in the consequence cause).						
O. Box 6	ing death commission y the attending physiched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	ath 3□	Ectopic pregnancy Other (specify)			23d. Date of del Month	very Day Year
<b>.</b>	0 0	by	Part II. Other significant conditions contributing to death but not resulting	g in the ur	derlying cause given in Part I.			acco use contribute to s 2 □ No 3 □ Pr	
Ĭ,	ate h	Completed					24a. Was an autopsy perform	/ prior to t	topsy findings available completion of cause of 2 No
	rnysicien: un this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1   Yes   2   7   No	(Qutpatien	Other		heck only one	nce 6 🗆 Other (Spe	rifu)
on of	ding rings h. After this c tuneral dir	Ilon; T	27. Manner of Death  1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b.	b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d		w injury occurred	
Division	r deat actor: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury · At home, building, etc. (Specify)	, farm, stre			Location (Str City or Town	eet and Number or Ru , State)	iral Route Number,
:	thin 24 hours after or thin 24 hours after or the Funeral Dirk mpletely filled in the	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled and manner stated.	dge, death and/or inv	occurred at the time, date and restigation, in my opinion, death	place, and occurred a	due to the ca at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
i	within 2 To the omplet	Σ	29b. Signature and title of certifier  Literat Q. Villa M.D.		29c. License number			OS/10	2005
5			30. Name and address of person who completed cause of death (Item 23:	a) (Type,		v e	Bo-1+	imore M	021237
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1 7 2005	di s	Good			/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year HUBBLE OF PM MARY 2 2005 4c. County of Death 4b. City, Town, or Location of Death 2300 DWANEY KD. VALLEY IMONIUM ACTIMORE If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 1 □ M 2 🗹 F Months Days Hours Min. 734.30.1578 Usual Residence of Decedent Yrs 10.14.1920 VIRGINIA 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No ULLERTON 10e. Street and Number 10g. Citizen of What Country? 21236 SA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 ☑Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPERMARKET ASHIER 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANTOINETTE ARLO OHN term30 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSSHILL RD SHAROW TLYNN BALTIMORE, MD 21234 ANGHERE2 Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State WILLS. MD 4 Donation 5 Other (Specify) FORES 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 21. Signature of Funeral Service Licensee 8800 IBI 10,220 TARKUILLE, MD 2:234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GALLBLADDER CANCER Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 1 Yes 2□ No 26. Place of Death (Check only one)

Physician /Medical Examiner Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral Director** 

Completed by

**Funeral** 

Director

28a-f show

item 27 is markad other than "natural", or Itams 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at

al Hygiene.

12 should be fi and Mental H

permit. Pages 1 Department of H Important: If ite any injury or ot

Baitimore, Maryland

2005

burial-transi as the use should be detached

the death certificate be executed in by the funeral director. or Attending after death. filled To the Hospital 24 hours a

P.O.

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Be Certification: To

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 Unknown

25. Was case referred to medical examiner? 2X No 1 Yes

27. Manner of Death 1X Natural

2 Accident 6 Could not be determined 3 Suicide 4 Homicide

1 Inpatient 5 Pending investigation

Hospital:

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

29b. Signature and title of certifier

104372

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

Medical

DHMH 17 Rev 1/2001

within 2

			-	For State Registrar	State of Maryland		nt of Health Ite of Deat		al Hygien Reg. N	7 11 11	16555
		•		Decedent's Name (First, Middle, La					te of Death	ay Year	3. Time of Death
		Physicia /Medic		MARY T	. HILL				5 10	5 2005	2 45 AM
		Examin	er	4a. Facility Name (If not institution, giv			y, Iown, or Locatic		Í	C. County of Death	1005
		Funeral			Sex 7. Age (In yrs. lasi	t birthday) If Und	ler 1 Year   If Und		ite of Birth lonth, Day, Yea	9. Birthp	place (State or Foreign
		Director		25.03.1474	1□M 2ØF 88	Yrs. Month	s Days Hour	s Min.	6.10	716 MAR	COLAJP
		and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Location				1	0d. Inside City Limits
		Maryl f sho	tor	MD RAIT	MORE	ARBU	TUS				1 Tes 2 No
		h the	irec	10e. Street and Number		10f.	Zip Code		10g. (	Citizen of What Cour	ntry?
		23a c	Funeral Director	1231 SEVEN			2122	7	(1.1. 1.1. 1.1. 1.1. 1.1. 1.1. 1.1. 1.1	14. Race - Americ	on Indian
		er de:	nne	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?		cedent of Hispanic becify Cuban, Mexi		, etc.)	Black, White,	
<b>.</b>	5-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show the Madical Exametra must be multied at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	22 No Spec	ify:		Specify: W	HITE
a.1	2-0	72 ho	eted	15. Decedent's E (Specify only highest gr		16a. Decedent's U (Give kind of	work done during n	nost of working		Kind of Business/In	
45	121	within ane. than *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	SECR	/		U	1.5. Gai	ERNMEN
2:	d 21	filed withi Hygiene. other then		17. Father's Name (First, Middle, Las	1)	<u> </u>		other's Name (Firs			
	<u>ılan</u>	should be nd Mental marked o	To Be	FRANCIS M	1c CARTHY		E	THEL /	4GNE		WIG
2002	Maryland	C 60 60 60		19a. Informant's Name/Relationship WILLIAM McCAR		19b. Mailing Addr	ess (Street and Nu	1.00		y or Town, State, Zip	
, 2		1 and 2 Health em 27 sther tra		20a. Method of Disposition	20b. Plac	ce of Disposition (	Name of	Date	20c.	Location - City or To	
16,	mor	0 0		1 Burial 2 Cremation 3 l	Removal from State	RISON FO	or other place)	5.24.20	∞5 C	WINGS	Mus, MO
MAY	Baltimore	permit, Peg Depertment Importent: I any injury o		21. Signature of Funeral Service Lice	Mor220	22. Name	and Address of Fa	RD RD	. Pack	LOF ME	MORIES 10 21234
				23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death. y one cause on each line.	Do not enter the n	node of dying, such	as cardiac or resp	oiratory arrest,		Approximate Interval Between Onset and Death
		Pnysician	i II	Immediate Cause (Final disease or condition resulting in death)	a OVARIAN CANC	ER					0.000 0.00
	1	/Medical- Examiner		resulting in death)	Due to (or as a conseque	nce of):					
			er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseque	nce of):					
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	90,	iicate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):					
	68760,	icate t physics the b	edical		d						
	Box (	eath certifi attending for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand		c pregnancy			23d. Date of deliv	
		requires that the death certi een signed by the attending hould be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 🗷 No	4 Pregnant at time of dea					Month	Day Year
	P.0	that the de led by the a		9 ☐ Unknown  Part II. Other significant conditions	contributing to death but not result	ing in the underlying	ng cause given in P	art I.	23e. Did tobac	co use contribute to	the cause of death?
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	CO	S .C. (2)	olete						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
		0 2 0	Completed						performed	l? death? No 1 ☐ Yes	_
H	of Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 Direction 2 DE		Other	lace of Death (Ch			
HILL	5	Physician: this certific ral director,	T.	1 Yes 2 No 27, Manner of Death	28a. Date of Injury 2	R/Outpatient 3 28b. Time of	28c. Injury at		5 Residence Describe how i	e 6 <b>X</b> Other (Speci njury occurred	HOSPICE
		Attending r death.	ation	1 XNatural 5 Pending 2 Accident investigat	(Month, Day Year)	Injury M	Work? 1 ☐ Yes	2 No			
MARY	Division	r Atter er dea rector by the	Certification;	3 Suicide 6 Could not determine	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, fac	ctory, office		ocation (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
2	Ö	oltel or ars afte rel Dir lled in						and since and	fue to the cour	o(s) and manner as	statod
		To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my know aminer: On the basis of examination and manner stated.	nedge, death occur on and/or investiga	tion, in my opinion,	death occurred at	the time, date	and place, and due	to the cause(s)
		To the Within 2 To the comple	Me	29b. Signature and little of certifier	)		29c. License num		29d.	Date signed (Month	
		1			10-		D437	125		5/16/	05
1		0		30. Name and address of person wh			DD mr	MONTINE .	m 2100		
		St	ate	DR. TARIQ MAHM 31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ıre		MONIUM, N	m 2109.	3	
		Regist		MAY 1	7 2005 Reserve	1. Core	R)				

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** May 13 2005 3:50A IAE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Elkridge 5915 C Abriana Way If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) April 22,1933 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1□ M 2ቖ F Korea 72 214-76-7207 Director Usual Residence of Decedent 10d. Inside City Limits Manyland 10c. City, Town or Location 10b County 10a State or 28e-f show other traumetic evant, the Mcdical Examiner must be notified at 1 ☐ Yes 2 No Director Elkridge Maryland Howard the ! 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any nijury or other traumer?" 238 U.S.A. 21075 5915 C Abriana Way Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Asian Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Business Owner 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sunee Park Suyong Kim 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fulton, Maryland 20759 12378 Pleasent View Dr. Christina Park (Daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition cemetery, crematory or other place) 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 5-16-2005 Marriottsville, MD Crestlawn `4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Itzke Funeral Homes, Inc. 555 Twin Knolls Road Columbia, Maryland 21045 21. Signature of Fundral Service Licensee M01280 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cance Pnysician Gall blidder /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: 23d. Date of delivery use 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No o 5 Other (specify) 4□Pregnant at time of death P.O. the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown should be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 🔲 Yes 2□ No 1 Tyes 2 No certificate I or Attanding Physician: after death. 26. Place of Death Check on one 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 in by the funeral dir this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 28c. Injury at Work? 27 Manner of Death Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 28I. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Mrs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m 412 Ni EUND 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 1 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 3:30 A 2005 May Harriett I. Hubble /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Woodbine 1164 Sean Circle If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** 1 □ M 25 F Maryland 68 Director 216 32 1260 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 反 No Woodbine Carroll MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21797 United States 1164 Sean Circle death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status hours after 1 Never Married 2 Marned 1 ☐ Yes 2√2 No Specify: Specify:White Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) Caton Radio Vice President 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be Iva B. Douglas Harry M. Sutton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Westminster, MD 21158 Anita Reich/ Daughter 5204 Tacker Lane 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important; If any injury or Crest Lawn Mem. Gards.5/18/2005 Marriottsville, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses permit. moio44 4112 Old Columbia Pk Ellicott City, MD 21043 Approximate Interval Between 23a. Pan1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death 5 months Immediate Cause (Final Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as the attending i IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 S No 4 Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 dUnknown 1 ☐ Yes 2 ☐ No been si 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 Yes 2/2 No 25. Was case referred to medical examiner? 26. Place of Death Check on one Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Selesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို this After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To the 29d. Date signed (Mon 29b. Signature and title of certifier Proces (Item 23a) (Tyre, Print) J egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7:25PM 2005 **Physician** Wesley F. Hullett MAT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALIMORE None SAINT AGHES HEALTHCARE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months 1⊠M 2□F 212 34 68 12/15/1936 Maryland 0525 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10b. County 10a. State 23a or 28a-f show ust be notified at 1 ☐ Yes 2 XNo Director Baltimore None 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Itams 23a or 21207 United States 5913 Prince George Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No 1960—
If Yes Give 2 should be filed within 72 hours after and Mental Hygiene. Is markad other than "natural", or Ital 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 62 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Newspaper 12 Printer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maryland . Pages 1 and 2 should be iment of Health and Mentalant: If itam 27 is marked Wesley F. Hullett, Sr. Estelle Orr othar traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5913 Prince George Street Baltimore, MD Almira Hullett/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Surial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department o Important: If any injury or once. 5/16/2005 Sykesville, MD Lakeview Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc 21. Signature of Funeral Service Licensee 4112 Old Columbia Pk Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONATIT YEXRS Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes \_2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28d. Describe how injury occurred 28b. Time of 27 Manner of Death Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attano within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P16705 BAFFEE-BOWNE, ANTHONY, MD 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATTOE - BONNE, MD, SAINT AGHES HEACTHCARE, BACTIMORE, MARRILAND

Registrar DHMH 17 Rev 1/2001

State

ANTHORY

31. Date filed (Month, Day, Year)

32. Resistrar's Signature

Marvin James 05-. AKG

210	,	1 - State Amend Item#1&2, Per ME	Maryland/1990	artment of Healt ertificate of Dea	itn	Reg. No.	16559
Dhuai		Decedent's Name (First, Middle, Last)		.7	2. Date of De Month	Day Year	3. Time of Death
Physic /Med		Melvin James			March	8 <del>, 2005</del>	10:47 P M
Exam			pt. 813	4b. City, Town, or Locati Baltimore		4c. County of Death	
Funera Directo		5. Social Security Number 6. Sex 13 M 2 F	7. Age (In yrs. last birthda) 81 Yrs.	Months Days Hou	urs Min. 8. Date of Bin (Month, Da	y, Year) Cou	place (State or Foreigr ntry) 1D
/land		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
Man a-f sh	tor	MD N/A	Baltin	ore			1★Yes 2 No
ith the or 28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	ntry?
eth wi			pt. 813	21213		USA	
72 hours after deeth with the Maryland 72 hours after deeth with the Maryland naturel; or Items 23e or 28e-f show disal Evart at most be rediffed at	Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  1 □ Yes : If Yes, Give	dent Ever in U.S. 13 ces? 2  No		c Origin? (Specify Yes or No xican, Puerto Rican, etc.)	3.00	
ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	tes:	1 ☐ Yes 2 ☐ No Spe	ocity:	Specify: Bla	ack
be filed within 72 hours aff tal Hygiene. d other then "naturel", or event, the Medical Evert	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupation re kind of work done during a DO NOT use retired)	most of working	16b. Kind of Business/In	dustry
filed within Hygiene. other then "ent, the Mer.	ошо	Elementary/Secondary (0-12) College (1-12th N/A	4or 5+)	ial Security	Admin.		
be filed that Hygis dother event.	BeC	17. Father's Name (First, Middle, Last)	· · · · · ·	18. M	Mother's Name (First, Middle,	, Maiden Surname)	
aryland A should be filed and Mental Hygis marked other umetic event, I	To E	Eugene Butler			Maggie	James	
2 × 2 × 2		19a. Informant's Name/Relationship (Type, Print) Gerard Scott—grandson		lling Address (Street and Nu Glen Barr Ci	umber or Rural Route Number t. Apt. D Pa	er, City or Town, State, Zij rkville, MD	21214
of Health fitem 27 ir other tre		20a. Method of Disposition	20b. Place of Dis	position (Name of ematory or other place)	Date	20c. Location - City or To	own, State
Pages ment of ent: ff it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S  1 ☐ Donation 5 ☐ Other (Specify)	tate	n Forest VA	5/17/2005	Owings Mill	s MD
Datumore, permit. Pages 1 au Department of Hea Importent: if item any injury or othe	i	21. Signature of Funeral Service Licensee		22. Name and Address of F	MARCH FUN	ERAL HOME-EA	
		23a. Part1. Enter the disease, or complications that ca	used the death. Do not e		h Avenue Bal		21202 Approximate
Pnysitia		shock, or heart failure. List only one cause on ea	ich line.	connach	scurpi	1918	Interval Between Onset and Death
/Medica	ı	disease or condition resulting in death)  a. Due to (c	or as a consequence of):	) ()2101/00/1	3 3000110	2412 28	
Examine	и.	Sequentially list conditions, b.					
ed lisit	inei	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence of).				
execut and al-trar	Examiner	that initiated events c.	or as a consequence of):				
death certificate be executed eattending physician and of for use as the burial-transit	dical	d					
rtificat ng phy	Medi	IF FEMALE:			<del> </del>		
leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		☐Ectopic pregnancy		23d. Date of deliver Month	ery Day Year
that the de ed by the a detached f	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			
The law requires that the take has been signed by the page 2 should be detached.	by Ph	Part II. Other significent conditions contributing to de	ath but not resulting in the	underlying cause given in P	Part I. 23e. Did t	obacco use contribute to t	he cause of death?
v require	led t				1 🗆 '	Yes 2 □ No 3 □ Prol	oably 4 Unknown
law requ	Completed				24a. Was	prior to co	ppsy findings available impletion of cause of
	Con				perfo 1 ☐ Yes	ormed? death? 2 No 1 Yes	2 🗆 No
OI VIIdi necolus, Physicien: The law requires t this certificate has been signe ral director, page 2 should be	Be	25. Was case referred to medical examiner? Hospital:		Other	Place of Death (Check only o		
Phy rathis	7.	1X Yes 2 □ No ☐ ☐ 1 □ Ir 27. Manner of Death	patient 2 ER/Outpati f Injury 28b. Time	of 28c. Injury at	Nursing Home 5 Residuel Residu	dence <b>&amp;</b> IXOther ( <i>Specii</i> how injury occurred	wat scene
nding I ath. r: After e funer	atior	1 X Natural 5 ☐ Pending (Month 2 ☐ Accident investigation	n, <i>Day Year)</i> Injury	Work? M 1 ☐ Yes 2	2 🗆 No		
or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place buildin	of Injury - At home, farm, : g, etc. (Specify)	street, factory, office	28f. Location (Sity or Tox	Street and Number or Rura wn, State)	al Route Number,
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune		29a. Certifier 1 Certifying Physicien: To the	best of my knowledge, de	ath occurred at the time, date	te and place, and due to the	cause(s) and manner as s	stated.
To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Exeminer: On the ba	sis of examination and/or er stated.				
To I To I	Σ	29b. Signature and title of certifier	A-2	29c. License numb	ber	May 9, 200	
- 414		Mayine the sky	te m	-		, ,	
811	-	s of person who completed cause	of death (Item 25a) (Typ.	111 Penn St	treet Baltim	ore, Marylar	d 21201
	tate	31. Date filed (Month, Day, Year) 32. Re	egistrar's Signature				
Regis	trar	MAY 1 7 2005	. H. Local	2			

		State of Maryland / State of Maryland /	Department of Ho		ental Hygien	Z IIII a	16560
Physici	an	1. Decedent's Name (First, Middle, Last)  Charles Tolbert Johnson Jr.			2. Date of Death Month D	ay Year	3. Time of Death
/Medi	cal.	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	May 15	c. County of Deat	
Examir		Washington County Hospital	Hage	rstowr	\	Wash	ington
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea	r) Co	hplace (State or Foreign untry)
Director		216 32 4327   124 M 2 L F   69	115.		Jan30,1936	Nor	th Carolina
yland now		10a. State 10b. County 10c. City, To	wn or Location				10d. Inside City Limits 1 ☐ Yes 2 No
e Mar	ctor	Maryland Washington Ha	agerstown		40.4	citizen of What Co	
death with the Maryland ms 23e or 28a-f show rmust be notified at	Funeral Directo	10e. Street and Number 15942 Broadfordind Rd.	10f. Zip Code 2174	0	10g. C	USA	unity
eath v	eral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hi		cify Yes or No-	14. Race - Ame	
. e . e . e . e . e . e . e . e . e . e	by Fun	Armed Forces?  1 □ Never Married 2☆ Married 1 □ Yes 2 ☒ No If Yes, Give  3 □ Widowed 4 □ Divorced Year or Dates:	If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	Specify:	rican, etc.)	Specify: Wh	· ·
Z 13-UU30 thin 72 hours af e. an "netural", or Madical Exam		15. Decedent's Education 16 (Specify only highest grade completed)	ia. Decedent's Usual Occupa (Give kind of work done of	during most of workir		Kind of Business	/Industry
Athin Athin Ban "Lean"	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	iite. DO NOT use retired orklift Opera		Fo	od Distr	ibution
0 0 0	e Co	8 17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maid	en Sumame)	
		Charles Tolbert Johnson Sr.		Lena Mae			
i, Maryland and 2 should be file ealth and Mental Hy n 27 Is marked oth ner traumetic event			9b. Mailing Address (Street of 5942 Broardfo				
of H		ceme	of Disposition (Name of tery, crematory or other place ens Of Faith (	(a)		Location - City or Baltimor	
Baltimo permit. Page Department ( Importent: If eny injury or		21. Signature () Funeral Service Ligensee	22. Name and Addre Bruzdzins	ss of Facility Ski Funera	l Home P. venue Ess	A. ex. Md.	21221
		23a. Pat 1. Enter the disease, or complications that caused the death. Dispock, or heart failure. List only one cause on each line.	o not enter the mode of dyir	ng, such as cardiac c	r respiratory arrest,		Approximate Interval Between
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/Medical Examiner	r i	resulting in death)  Due to (or as a consequence					
Examine		Sequentially list conditions, if any leading to immediate  b. Due to (or as a consequence)					
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
8760, cate be executed only sician and the burial-transit	Ical Exa	resulting in death) Last Due to (or as a consequent	ce of):				
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Box death cer e attendir d for use	by Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	ath 3 ∐Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year
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<b>~</b> 0 ← 0	Completed				24a. Was an autopsy performed	prior to death?	
Vital Fician: The certificate rector, pag	O)	25. Was case referred to medical		26. Place of Deat	h Check onl one		
> 0 0	To B		Outpatient 3 DOA	- +	me 5 Residence		ecify)
on c ling P	inol.	27. Manner of Death 1 Natural 5 Pending (Month, Day Year)		rk? ]Yes 2 □No	284. Describe now	injury occurred	
Division  or Attending after death. Director: After	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)			28f. Location (Stree City or Town, S	t and Number or litate)	Rural Route Number,
Hospita 4 hours Funerel	edical Ce		edge, death occurred at the t n and/or investigation, in my	ime, date and place, opinion, death occur	and due to the caus red at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
,	Mec	29b. Signature and title of certifier  Taim Wilher		se number 060396		Date signed (Mo	nth, Day Year)
10 %		30. Name and address of person who completed gause of death (Item 2.	~9	6 opal	mo	1217 L	astomy
Regi	State strar	BANY 1 PY OODE NEWS	" forthe				

ADH BILL JONES 05-3342

JJ42	1	For State Registrar	State of Mary		artment of H rtificate of I			200	5	16561
		I. Decedent's Name (First, Middle, Last)					2. Date of De		Vaar	3. Time of Death
Physician /Medical		Bill	Jones	Jr.			1	14/ <sup>pay</sup> 2005		1109 A M
Examiner	_	a. Facility Name (If not institution, give s GOOD SAMARITAN HOSI			BALTIMOR	r Location of Death RECITY	1	4c. County	of Death /A	
Funeral Director		i. Social Security Number 6. Sex		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 12 2	th y, Year) 24 1924	9. Birthpl Count VA	ace (State or Foreign ry)
and w	-	Jsual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				10	Od. Inside City Limits
Mary a-f sho illing:		MD N/A		Balt:	imore					1 ¥ Yes 2 □ No
th with the Mar 23a or 28a-1si at Le noriffed ai Director	-	Oe. Street and Number 501 E. Preston St	reet Apt	. 509	10f. Zip Code	21202		10g. Citizen of V US		try?
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be nuffited at once.  To Be Completed by Funeral Director		1 Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever Armed Forces?</li> <li>1</li></ol>		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🕱 No		pecify Yes or No o Rican, etc.)	Specify	e - America ck, White, e	
21215-00 ed within 72 hou yajene. Per than "nature to the world to the		15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king	16b. Kind of Bu	usiness/Ind	ustry
within within the with		Elementary/Secondary (0-12)	College (1-4or 5+) N/A		aborer	3)		Domino	Pofi	noru
be filed tal Hyg d other event,		7. Father's Name (First, Middle, Last)			u.o.c.	18. Mother's Nan	ne (First, Middle,			ner y
ylai lould b I Menti narked natic e		Bill Jones	Sr.			Ida		Ash		
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Baltimore, oermit. Pages 1 an Department of Heal mportant: If item? any injury or other page.	2	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	2	Ob. Place of Dispo	sition (Name of matory or other place Le VA Cem	ce)	Date 0/2005	20c. Location -	City or To	
Baltin permit. I Departm Importal any inju		21. Signature of Funeral Service License	w and		Name and Addres					T 21202
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ion nding ath. r: Ate e fune		1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Ye	ar) Injury	Wor	k? Yes 2 □ No				
Division of Vital Records, tet or Attending Physicien: The law requires the stater death.  et Director: After this certificate has been signed in by the funeral director, page 2 should be certification; To Be Completed by		3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str Specify)	eet, factory, office		28f. Location (S City or To	Street and Numb vn, State)	er or Rural	Route Number,
the Hospite thin 24 hours the Funere mpletely fille			ician: To the best of mer: On the basis of exa and manner stated.	mination and/or in						
To the within To the comp		29b. Signature and title of certifier	^	,	29c. Licens	e number ME		29d. Date signed		
	-	rarola	lanna	(lie - 00-) =	D-i-a)				, 200	
3+1		30. Name and address of person who co	mpleted cause of death  ANW  Registrar's	1	TT11 Penn	Street	Baltimo	ore, Mar	yland	21201
State Registrar		MAY 1 7 2005		-	No.					

N.JM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-03058 State of Maryland / Department of Health and Mental Hygiene Dewayne James For **Physician** /Medical Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland rel', or Items 23a or 28a-f show Expendent court be notified at Completed by Funeral Director Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hr
Department of Health and Mental Hygiene.
Importent: If Item 27 is marked other then "naturent injury or other traumatic event, If e Michael Be ပ

- State Registrar					Cer	tificat	e of L	)eath			Reg. N	ō.	U W	100	V Cu
1. Decedent's Name (First, Mic	ddle, Las	st)								2. Date of De		21/	Voor	3. Time of D	)eath
Deway	ne	James								May	3 <sup>D</sup>	2	2005	0235	М
4a. Fecility Name (If not institu	tion, give	e street and nu	ımber)			4b. City,	Town, or	Location	of Death		4	c. County	of Death		
Prince Georg	e's	Hospit	a1 (	enter	.	Che	ver1	V				Prin	ice G	eorge's	
5. Social Security Number	6. S			(In yrs. last		If Under		If Under		8. Date of Bi (Month, D			9. Birth	place (State or	
578-11-4823	1	<b>⊠</b> M 2□F		19	Yrs.	Months	Days	Hours	Min.	May 30	), 1	985	Wash	ington	DC
Usual Residence of Decedent															
10a. State 10b. Cou	nty			10c. City, 1	Fown or Lo	cation								10d. Inside City	Limits
DC				Was	shing	ton D	C							1½ Yes 2	2 🗌 No
10e. Street and Number						10f. Zip	Code				10g. C	itizen of	What Cou	ntry?	
4707 B Stree	et S	Е					2001	9				U.S	S.A.		
11. Marital Status		12. Was Dec		ver in U.S.	13. \	Nas Dece	dent of H	ispanic Or	igin? (Sp	pecify Yes or N Rican, etc.)	0-		ce - Ameri	can Indian,	
1 Never Married 2 □ N	<b>Narried</b>	1 ☐ Yes	2X N	lo						y mount, orony				Black	
3 ☐ Widowed 4 ☐ Divor	ced	If Yes, G Year or				1 🗌 Yes	24LI No	Specify:				Speci	ry:	Diuck	
15. Dece (Specify only hig	dent's E	ducation ade completed	)		16a. Deced	dent's Usu kind of wo	rk doné d	during mos	st of wor	king	16b.	Kind of E	Business/Ir	idustry	
Elementary/Secondary (0-1 1 1	2)	College	(1-4or 5	+)		abore		,			]	Priva	ate		
17. Father's Name (First, Midd	dle, Last	)						18. Moth	er's Naπ	ne (First, Middle	e, Maide	n Suma	me)		
Kenneth I									Lin	da Nove	11a				
19a. Informant's Name/Relati	onship (	Type, Print)			19b. Mailir	ng Address	s (Street	and Numb	er or Ru	ral Route Numi	ber, City	or Town	, State, Zi	p Code)	
Tawana Jame	es-S	tevens-	- Au	nt	340	2 Spe	ctac	ular	Bid	Court	Вот	wie l	MD 20	721	
20a. Method of Disposition				20b. Plac	ce of Dispo	sition (Na	me of	1		Date	20c.	Location	- City or T	own, State	
1 ☑ Burial 2 ☐ Cremati 14 ☐ Donation 5 ☐ Othe			n State		netery, crei L Lin				5/	9/05	В	rent	wood,	MD	
21. Signature of Funeral Ser	Lice	nsee			22	2. Name a	nd Addre	ss of Facil	ity Fo	rt Linc	o1n	Fun	eral	Home	
1		-			3	401 B	lade	nsbu	rg R	oad Br	ent	book	MD 2	0722	
23a. Part1. Enter the disease shock, or heart failure.	e, or com	plications that one cause on	caused each lir	the death.							arrest,			Approximate Interval Betw Onset and D	reen
Immediate Cause (Final disease or condition resulting in death)	-	a	₩ o (or as	a conseque	ince of):	(2)	of t	tead					-	Orisot and D	Call
Sequentially list conditions.		b											_		

**Physician** /Medical **Examiner** 

attending physicien and for use as the burial-transit

for

The law requires that the death certificate be exect

To the Hospitel or Attending Physicien:

filled in by the funeral director,

this

after death.

within 24 hours a To the Funerel C

Division of Vital Records, P.O. Box 68760,

Examine

by Physician/Medical

Completed

Be

2

Certification:

Medicai

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 III Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Year

16562

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes

24a. Was an autopsy performed? 1 Yes

24b. Were autopsy findings available prior to completion of cause of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

death? 2□ No

25. Was case referred to medical examiner? 1 X Yes 2 No 27 Manner of Death

29b. Signature and title of certifie

5 Pending

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) investigation 5/2/05

28b. Time of (Fam.)28c.

At home, farm, street, factory, office

107

2 No

28d. Describe how injury occurred SUBJECT SHOT

Location (Street and Number of Rural Route Number, City or Town, State) 4514 (NNN) (URC) Southeart, WAIHLIPTEN

29a. Certifier

1 Natural

2 Accident

4 Homicide

Suicide

1 Certifying Physician: To the best of my knowledge, d ath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury · At hor building, etc. (Specify

29c. License number OCME

29d. Date signed (Month, Day, Year)

May, 3, 2005

31. Date filed (Month, Day, Year) State

2005



30. Name and address of person the completed cause of death (Item 23a) (Type. Print) 111 Penn Street Baltimore, Maryland 21201

Registrar

PAYKING

n-0	3238		1 - State Unpend Item				nt of Health an			_	ic.	65	63
			Registrar  1. Decedent's Name (First, Middle, Last		i me q	Certifica	te of Death	2. Date of		a. U U \	J	3. Time of	Death
	Physicia /Medic	al	Kevin 1	=	Jones			May	05	2	005 5	5:15	Рм
	Examin		4a. Facility Name (If not institution, give 2109 North Pulask	street and number) i Street		1	Town, or Location of Caltimore			c. County of	Death N/A		
	Funeral Director		330-09-7740	X 2□ F 7. Age	(In yrs. last birtl		or 1 Year If Under 24 Days Hours I	Min. 8. Date of Month	of Birth	56	Birthplace Country Vif gi	ce (State o	r Foreign
)	aryland show	7	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town					-	100	I. Inside Cit	
	28e-f	recto	10e. Street and Number		Baltim		ip Code		10g. C	itizen of Wh	at Country		2 1110
	23a or	ral DI		St.			216		USI				
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatih and Mental Hyglene. Importent: If item 27 is marked other tran "naturel", or Items 23a or 28a-f show says injury or other traumatic event, the Medical Exams at must be multiplied at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Dec If Yes, sp 1 \( \subseteq Yes	edent of Hispanic Origin ecify Cuban, Mexican, P 2 No Specify:	? (Specify Yes o Puerto Rican, etc	or No-	14. Race - Black, Specify:	American White, etc		
21215-0036	within 72 ho ene. than "natur te wedical.	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+	)	(Give kind of w life. DO NOT	,	f working		Kind of Busi		•	
d 21	be filed wital Hygier of other ti		17. Father's Name (First, Middle, Last)			abore		Name (First, Mi		lareh			BA
/lan	should be nd Mental marked o	To Be	Clifton M. Jone	25			Dottie	e L.	Clar	k			
Maryland	1 and 2 sho Health and tem 27 is my		19a. Informant's Name/Relationship (7) Keith Jones - b	rother	19b.	Mailing Address	Street and Number of	1 0 1	umber, City		ate, Zip C	ode)	
ore,	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition  1 Burial 2 ☐ Cremation 3 ☐ 6		20b. Place of cemetery	Disposition (N. crematory or	other place)	Date	20c.	ocation - C	,		
Baltimore,	permit. Pag Department Importent: I any injury o		4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Uses		Sacrea	22. Name	of Jesus 5	16-05	Dur	idaik	', m		04.0
	80 = 90	9 19	23a. Part ser the disease, or comp	lications that caused t	he death. Do n	CURY P	MARCH FIH 2	AMOFred		ass b		MD 0	
	Physician		Immedia e Cause (Final disease or condition	ne cause on each line a <b>Cirrhosi</b>	).				, y a		- Ir	nterval Bety Inset and D	ween
	/Medical Examiner		resulting in death)	Due to (or as a	consequence o								
	ted sslt	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.	consequence o								
,092	ate be executed hysicien and he burial-transit	l Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence o	f):							
6876	ficate by physic is the bi	edical	•	d									
.O. Box	The law requires thet the death certifical site has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 Dectopic				23d. Date Month			ear/
Δ.	res thet ti igned by be detac	by Ph	Part II. Other significant conditions co	ntributing to death but	not resulting in	the underlying	cause given in Part I.			use contrib		1.	
Records,	w requir been si should	leted							1 □ Yes Was an	2 No 3		y findings a	1
al Re		Completed						_	autopsy performed? es 2 \( \)	pri	or to comp ath? Yes 2	oletion of ca	iuse of
Vital	Physiclan: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 □XYes 2 □ No	Hospital: 1 ☐ Inpatien	t 2 ER/Out	patient 3 🗆 [	Other	Death (Check)		ext Other	/Casafil		
ion of	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification; To	27. Manner of Death    Natural 5   Pending   P	28a. Date of Injury (Month, Day	28b. T		28c. Injury at Work? 1 Yes 2 No	28d. Desc		6X Other ury occurred		IL SCE	ene
Division	al or Atter after de l Directo d in by th	ertiflo	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, far (Specify)	m, street, facto	ry, office		ion (Street a r Town, Sta	and Number te)	or Rural F	Route Numi	ber,
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in	edical C	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam	sician: To the best of ner: On the basis of a and manner state	examination and	death occurre Vor investigation	d at the time, date and p n, in my opinion, death	place, and due to occurred at the t	the cause( ime, date a	s) and manr nd place, an	ner as state d due to th	ed. ne cause(s)	)
	To the within To the comp	M	29b. Signature and title of certifier	- Pals	Del un	2	OCME			ate signed (		ay, Year)	
			30. Name and address of person who c	ompleted cause of de	ath (Item 23a) (	Type, Print) 111	Penn Stree	t Balt	imore	, Mary	land	2120	1
	Sta Registr		31. Date filed (Month, Day, Year)	32. Begistrar		A. W							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 32 JOHNSON OLAFUR 12 2005 May KENNETH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOPKINS HOSPITAZ BALTIMORE CITY JOHNS If Under 1 Year If Under 24 Hrs. Min. Month, Day, Year May 18, 1938 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1∑M 2□F 66 Canada 536-34-0575 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23s or 28s-f shov the Medical Examinar must be nutified at f∑Yes 2 □ No N/A Baltimore Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21218 3801 Canterbury Road Apt.618 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married Married 1 ☐ Yes 2X No Specify: White Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than College (1-4or 5+) Elementary/Secondary (0-12) College Professor 5+ permit. Pages 1 and 2 should be filed w Department of Haalth and Mental Hygler Important: If item 27 is marked other it any injury or other traumatic event, Ita once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Emma Gislassen Marin Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3801 Canterbury Road Apt. 618 Baltimore, MD 21218
ce of Disposition (Name of Date 20c. Location - City or Town, State Jennifer Johnson, Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 05/13/05 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Utensee
Thomas Gregor <sup>22</sup> Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2 year lon **Physician** ancei 0 /Medical Due to (or as a consequence of): 2 weeks **Examiner** 0 + Fusion leural Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending newsprian and Exami physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE for use 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Yes 2V2No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 5 Pending Natural 1 | Yes 2 | No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 12 MO May HOSPITAL 600 NORTH WOLFE STREET, BALTIMORE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

MD 21287

M.O. TOHNS HOPKINS

32. Registra's Signature

2005

NALLU

31. Date filed (Month, Day, Year)

				For State Registrar	State of Ma	ırylanı	•	artment rtificate			and M	- '	giene Reg. No.	005	1656	5
				Decedent's Name (First, Middle, Last)		-						2. Date of Dea	ath Day	Year	3. Time of De	ath
		Physici /Medio		Ruth May K	ersev							May	14	2005	1225	A M
-(		Examir		4a. Facility Name (If not institution, give str				4b. City,	Town, or	Location o	f Death		4c. (	County of Deat		
	3			Franklin Square	Hospi	tal		T	205	edo	ule			Balt	more	
		Funeral		5. Social Security Number 6. Sex	7. Age		ast birthday)	If Under Months	1 Year Days	Il Under 2 Hours	24 Hrs. Min.	8. Date of Birt	h v Year)	9. Birt	hplace (State or Fo	oreign
	н	Director		162-22-8650	4 2 💢 F	79	Yrs.	Months	Days	Hours	Muri.	8. Date of Birt (Month, Date 10/18/	1925		nsylvani	
		pu ,		Usual Residence of Decedent		40- 03										
		anyla show	_	10a. State 10b. County		10c. City	r, Town or Lo	cation							10d. Inside City L	
		Be-f	cto	Maryland Baltimor	e	Wh	ite Ma	rsh							1 🗆 Yes 2	M MO
		if th	Oire	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Co	untry?	
		23a	ai	11025 Pulaski High				211						S. A.		
		r de la	Funeral Director		. Was Decedent 8 Armed Forces?		S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Orig n, Mexican	gin? (Spe i, Puerto	cify Yes or No- Rican, etc.)	- 1	<ol> <li>Race - Ame Black, Whit</li> </ol>		
	36	or It	Y	1 Never Married  Married	1 ☐ Yes 2 📉 N If Yes, Give	lo		1 ☐ Yes 2	2X No	Specify:				Specify: -		
	21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or tlems 23a or 28e-f show ont, the Medical Example must be posified at	d by	3 Widowed 4 Divorced	Year or Dates:									Wn	ite	
5	5	"nat	Completed	15. Decedent's Educa (Specify only highest grade of			(Give	dent's Usua kind of wor DO NOT us	rk done d	turina most	t of worki	ng	16b. Kir	d of Business/	Industry	
7	12	withir	m du	Elementary/Secondary (0-12)	College (1-4or 5	+)			e reurea,	,			~~	IIomo		
RUH		filed within the file of the f	ပိ	12 17. Father's Name (First, Middle, Last)			Homen	aker		18 Mothe	r's Name	(First, Middle,		Home		
1-	anc	ed fall	Be											, i		
	Ë	should be that Mental B marked or umatic every	2	John Klemm	(Color)		405 44-16-	- 4 - 1 - 1 - 1 - 1 - 1	(0)	Dor:			nown			
T	Maryland	~ @ # #		19a. Informant's Name/Relationship (Type				_				/ Route Numbe				
Sei		1 and 3 Health tem 27		Larry Kersey (Son)		20h B		Pula				White I			land 211	62
<b>(</b> )	ore	ges 1 a t of Hea If item or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer	noval from State	200. F	lace of Dispo emetery, crea	matory or o	ther place	e)			20c. Lo	eation - City or	lown, State	
2	Ē	Pa men men ury		' 4 ☐ Donation 5 ☐ Other (Specify)		Oak	Lawn	Cemet	ery	1	560	5	Bal	timore,	Marylan	ıd
~	Baltimore,	permit. Pages 1 Department of F Important: If ite any injury or ot	1	21. Signature of Funeral Service Licensee	1 11		22	2. Name an	d Addres	s of Facilit	y nora	Home '	Dλ			
	ш	20 = 20		Michael C. 2	office	2 8	7	4050	old E	<u> astei</u>	rn A	venue :	Esse	x, Mary	land 212	21
				23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	tions that caused cause on each lin	the death	. Do not ent	ter the mod	e of dying	g, such as	cardiac c	r respiratory ar	rrest,		Approximate Interval Between	en
		Physician	١.	Immediate Cause (Final disease or condition	0										Onset and Dea	ath
		/Medical		resulting in death)	Due to (or as			-							2 weel	5
		Examiner														
			je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):									
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	ó	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or as	a consequ	uence ol):									
	Box 68760,	cate be ohysicia the bu	cai	d.												
	68	leath certifical attending phi I for use as th	ed													
	ŏ	andin use	Physician/Med	230. Was decedent pregnant	c. If yes, outcome			Tratagia ar					2	3d. Date of del	ivery	
	Β.	death e atte	icia	in the past 12 months? 1 □ Yes 2 🗵 No	4 Pregnant at			⊒Ectopic pr ☐ Other (sp						Month	Day Yea	1r
	P.O.	t the by th ache	hys	9 🗆 Unknown	9□ Unknown											
		res that the de signed by the a I be detached f	by P	Part II. Other significant conditions contr	ibuting to death bu	ut not resu	utting in the u	inderlying c	ause give	en in Part I.		23e. Did to	obacco us	se contribute to	the cause of deal	.th?
	rds	quire n sig uld b										101	Yes 2	XNo 3□Pr	obably 4 🗀 Unk	nown
	of Vital Records,	w requir been si should	Completed									24a. Was	an	24b. Were au	topsy findings ava	ailable
	Re	The lay	mc									autop perfo	rmed?.	death?	topsy findings ava completion of caus	se of
	e	icien: T certificate rector, pa	CO	25. Was case referred to medical						00 Pl	-1.0	1	2000	1 ∐ Yes	2 No	
	<u> </u>	sicien: certific irector,	00	examiner?	spital:	a 🖂	ER/Outpatier	** 2000	Othe			n <i>(Check only o</i> me 5 ☐ Resid		70.5 /0	-74-7	
	of	Phys ral di	. To	27. Manner of Death	28a. Date of Injur	-	28b. Time o		8c. Injury	4 ∐ Nu ⁄at		me 5 L Hesion 128d. Describe I			опу)	_
	on	ding h. h. After funer	tlor	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	i Year)	Injury	м	8c. Injury Work	k? Yes 2 ∭ l	No					
	S	oteath. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	urv - At ho	me. larm. st	reet, lactory				281. Location (S	Street and	f Number or R	ıral Route Numbei	r.
	Division	after Dire	Certification:	4  Homicide determined	building, etc	c. (Specify	()	, , , , ,	,			City or Tox				
		spite ours nerel filled		29a. Certifier Decertifying Physic	cian: To the best of	of my kno	wiedne, deat	h occurred	at the tim	ne date an	d place.	and due to the	cause(s)	and manner as	stated	
		24 h 24 h 9 Fur etely	edical	(Check only 2 Medical Examine one)	r: On the basis of	examinal	tion and/or in	vestigation,	, in my or	pinion, dea	th occurr	ed at the time,	date and	place, and due	to the cause(s)	
		To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	₹	29b. Signature and title of certifier	7//	//		290	. License	a number			29d. Date	signed (Mont	h, Day, Year)	
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		- ~		30. Name and address of person who com	inleted cause of d	eath (Ita-	23a) /Tuno	Print)		100	77	> /	1017	14 20	レフ	
	1	2		30. Name and address of person who com	Viciou cause or a	3000	Frank II	n Scir	Lre	Drive	- 1	Zaltin	OFP	ME	2123	7
			ate	31. Date liled (Month, Day, Year)	32. Resistra	ar's Signa	tureg	danil.				<u></u>				
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 **Physician** Krairo jamanan 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Twiford Ct: Ellico # Ct Howard C City 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State of Country) **Funeral** Days Hours 100M 2□F 219-15.2463 96 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f show the Medical Examinar must be natified at Howard Ellicott Md 1 ☐ Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Thai 21042 Funerai Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status I □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) watchmaker permit. Pages 1 and 2 should be file Dep-rtment of Health and Mental Hy Important: if item 27 is marked othe any njury or other traumatic event, 2005; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) China Not 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Van -vaino 1 ananan 20a. Method of Disposition 200. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 □Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/13/05 Baltimore. MD 21. Signature of Funaral Service Licensee <sup>22</sup> Came and Address of Eacility. Cremation Society of Maryland, Inc. McDonald 299 Frederick Road Baltimore, MD 21228 Approximate Interval Betwee Onset and De 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac **Physician** WKS. /Medical Examiner mos, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner MOS signed by the attending physician and d be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No 23e. Did tobacco use contribute to the cause of death? conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy this certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 1 17 Yes 2 □ No 28d. Describe how injury occurred 28b. Time of 5 Pending investigation М 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Prysician. To the best of my knowledge, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number no completed cause of death (Item 23a) (Type, Print) 20 Registrar's Signature Wilkens Ave 4001 aman. 31. Date filed (Month, Day State Registrar

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	g		Decedent's Name (First)	, Middle, Las	:t)								2. Date of De.	ath			3. Time of	Death
	Physicia		Verna	В.	Knopi	Ē							Month May 7,	200°		ar .	9:40	AM
	/Medic Examin		4a. Facility Name (If not in:						4b. City,	Town, or	r Location of		<i>,</i> , <b>,</b>		County of D	eath		41
			Gilchrist C	enter	Hospice	2			Balt						N/A			
	Funeral		5. Social Security Number	6. Se	ex □M 2X0F	7. Age (	In yrs. last		If Under Months		If Under Hours	Min.	8. Date of Bird (Month, Da	y, Year)	9. (	Birthplac Country	ce (State or	r Foreign
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y Jai	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28a-f show raumatic event, the Medical Exarcher must be notified.	To	(unknown)		Gard	lner							e Ownes					
Maryland 21215-0036	d 2 should be filed v h and Mental Hygie 7 Is marked other t traumatic event, Ib		19a. Informant's Name/Re Richard Mar:						_				Route Numbe	-				
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Baltimore,	ages to tr if ite		1 X Burial 2 □ Cren	nation 3 🗆		State	20b. Place ceme										i, State	
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Ba	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other trau		Kim	1	chla	100		-			e, MD			.Kem	. Aven	16		
			23a. Part1. Enter the dise shock, or heart failur	ase, or comp	plications that of	aused	ne death. D	o not ent						rrest,		A	Approximate	9
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7/c	death e atte	Iciai	in the past 12 month 1 Yes 2/1 No		4□Pregr	nant at tir	Fetal death		]Ectopic p ] Other (sp		/ 			-	Month	D	ay Y	/ear
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 8 per H, G843,05/20/05 debitificate of Death

Reg. No. 15 16568 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year May 8, 2005 The1ma Kropf Mildred 8:15 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Roland Park Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 12/15/12 Birthplace (State or Foreign (Month, Day. 12/15/12) 6. Sex +**X** M 2**X** F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Yrs. Director 92 Dec. 15, 2005 Maryland 212-05-1090 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A1 X Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4431 Buena Vista Avenue USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilhelmina Reuwer Charles Fischer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2939 Craigston Ln. Abingdon, MD 21009 Joyce Scarcella 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 05/13/05 Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, MD 21229 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical BREAST CANCER Examiner Due to (or as a consequence of): Examiner The law requires that the death certificete be executed ettending physician and I for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) signed by the et d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ALTHEIMER'S DISEASE ð 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen Jas page 2 2 No certificate 1 □ Yes 1 ☐ Yes 2 ☐ No al or Attending Physician: T s efter death. al Director: After this certificat ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 27. Mover of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 I Homicide To the Hospital o within 24 hours of To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) D16619 Cullant Spar MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4669 FALLS RD. BALTIMORE, M.D. 21209 C. VERGARA-SOARES 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			1 - For Amend Item 9 Registrar	State o per fh	f Waryland	17-05 17-05 Cer	artment of l tas rtificate of	Health and N <i>Death</i>	Mental Hyg	iene	16569
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			NORTHWEST HO		CENTER			ALLSTOWN		BALTI	
	Funeral Director		5. Social Security Number 217-20-5414	.Sex 1 <b>∆ X</b> 2□ F	7. Age (In yrs. la:	st <i>birtnday)</i> Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month Day) 12/13/	1928	9. Birthplace (State or Foreign
			Usual Residence of Decedent		, 0				12/13/	1720	PIARTHAND - II
	ylanc		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
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	3s or 26	i Director	10e. Street and Number 2218 ASHBURT	ON STRE	ET		10f. Zip Code	1216	1	0g. Citizen of Wi USA	
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altimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from		ce of Dispo	sition (Name of	ropu	Date	20c. Location - C	ity or Town, State
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Ball	permit. Page Department of Importent: if any injury or once.		21. Signatur Fineral Service Lie	censee	Course	- 19	Name and Address	. 11			HOME 21207 LTIMORE, MD
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<b>Q</b>	that the by detact		Part II. Other significant condition	s contributing to d	eath but not result	ing in the u	nderlying cause gr	ven in Part I.	23e. Did tob	acco use contrib	oute to the cause of death?
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	To the Hospitel or At within 24 hours after of To the Funerel Dirac completely filled in by	edical (	29a. Certifier (Check only one)  Certifying  Certifying	aminer: On the b	best of my knowl asis of examination ner stated.	edge, death on and/or inv	n occurred at the tivestigation, in my	ime, date and place, opinion, death occur	and due to the cared at the time, da	ause(s) and manrate and place, an	ner as stated. d due to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician 1:50 AM LEWIS 2005 /Medical 4c. County of Death street and number) 4b. City, Town, of Location of Death 4a. Facility Name (If not institution, give Examiner ALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, MAKCH 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Funeral Days SOUTH 1 ☐ M 2 ☐ F AROLINA Director Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 28a-f ehow other traumatic event, the Madical Exactines must be notified at MD DATIMORE 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ U.S.A. Completed by Funeral 14 Bace - American Indian. 1 ☐ Yes 2 ÎNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ŏ Specify. 4 Divorced 3 ☐ Widowed "neturel" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

SAUCS 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other then "r Elementary/Sedondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider Be 19b. Mailing Address (Street and Number or Rural Route Number, City or 30) 10 NFRI AND HE. BATTO 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an Department of Health a Importent: If item 27 Is eny injury or other tra (DAVGHTEK) 20b. Place of Disposition (Name of 20a. Method of Disposition Burial 2 Cremation 3 □Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee BAUTIMORE, MO Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GASTIZIC Physician Lymphoma mon TH /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit byen 1a Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 XNo 3 Probably 4 □Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes certificate the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 3□ DOA P 2 ER/Outpatient this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 2 No 1 Tyes after death 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature/and title of certifier D25373 and address of person who completed cause of death (Item 23a) (Type, Print) JERRY BENSON HUMIT, MO 2009 DRVIO HII Are BATIMORE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

			For State Registrar	State of Ma	•	artment of He	ealth and Mental	Hygier	711115	16571	
			1. Decedent's Name (First, Middle	, Last)			2. Date Mont	of Death	ay Year	3. Time of Death	
	Physicia /Medic		Raymond	Lane			May	11		8:00A M	
	Examin		4a. Facility Name (If not institution	give street and number)		4b. City, Town, or I	ocation of Death	4	c. County of Deatl	1	
П			6598 Seneca D	rive		Columbi			Howard		
	Funeral		5. Social Security Number	25	e (In yrs. last birthday)	If Under 1 Year Months Days	Hours Min. 1 0 Mon	of Birth th, Day Yea 4-193	9. Birti	nplace (State or Foreign untry) h Carolina	
	Director		239-42-7756	18 M 2 L 1	73 Yrs.		10-1	4-193	Nort	n Carolina	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23a or 28a-1 show aumstic event, the Modrell Examiner must be notified at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits	
21215-0036		5	Maryland Howard	1		Colum	nbia			1 ☐ Yes 2 🌣 No	
		Funeral Directo	10e. Street and Number			10f. Zip Code			Citizen of What Co	untry?	
			6598 Seneca Dri	re		21046		Un	ited Stat	tes	
		ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of His	panic Origin? (Specify Yes , Mexican, Puerto Rican, et	or No-	14. Race - Ame Black, White		
	or Ite	To Be Completed by Fu	1 ☐ Never Married 2 🖾 Marri		1948-	1 ☐ Yes 2 █ No	Specify:	0.,		hite	
	"natural",		3 Widowed 4 Divorced								
			15. Decedent (Specify only highes	s Education t grade completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of working		Kind of Business/	•	
12	withir ane. then		Elementary/Secondary (0-12)   College (1-4or 5+)			cact Specialist			epartment of Defense		
N	filed Hygie othar		17. Father's Name (First, Middle,	_ast)	00110	<del> </del>	18. Mother's Name (First, M	fiddle, Maid	en Sumame)		
	t. Pages 1 and rtment of Health rtant: If Itam 27 njury or other tr		William Yates	Lane			Arthie Weave	r			
Maryiand							ess (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Ž			Eileen Lane (	Vife)	6598	Seneca Dr.	., Columbia,	MD 21	046		
ē,			20a. Method of Disposition			sition (Name of natory or other place			Location - City or	Town, State	
Ê			1 ☐ Burial 2 ☑ Cremation  1 ☐ Donation 5 ☐ Other (S)				ry   05-14-20	05 Be	ltsville,	Maryland	
Baltimore,			21. Signature of Pineral Service	iconsee	13 <sup>2</sup>	Name and Address	of Facility Homes, I	nc.		-	
m	Depa Impo any Ir		Call	M	01290 5	555 Twin E	Knolls Rd., C	olumb	ia, MD 21	L045	
of Vital Records, P.O. Box 68760,	The law requires that the death certificate be executed with the death certificate be executed many page 2 should be detached for use as the burial-transit	Physician/Medicai Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or in ary that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a	a consequence of):  a consequence of):  a consequence of):  of pregnancy 2   Fetal death 3	CanGr			23d. Date of del Month	Interval Between onset and Death onset and Dea	
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	ictan: The faw requ certificate has been rector, page 2 shoule	To Be Completed	Jone mefastages			auto		Was an autopsy performed Yes 2	prior to completion of cause of		
	Physician: r this certifice ral director, I		25. Was case referred to medical axaminer?								
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funarat Diractor: After this certificate ha completely filled in by the funeral director, page		Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
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S		Certification:	Accident investigation  3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, far building, etc. (Specify)							Street and Number or Rural Route Number,	
Division		ertif				City or Tow					
	spita ours narai filled	Medical Ce	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	24 h 24 h Fur letely		(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the vithing to the comp	Me	29b. Signature and title of certifier 3 Section 1 29c. License number 29d. Date signed (Month, Day, Year) 5 - 12 - 2005								
	1		30. Name and address of person	who completed cause of	leath Item 23a) (Type,	Print) ./ I	1 . 1	1	11.	112 01010	
	2 Sta	té_	31. Date filed (Month, Da), Year)	32. Registr	- 2401 rar's Signature	W. DELV	EDENE AVE	5.,DA	HIMORE	MD alab	
	Registr	ar	MAY 17	2005	, 14 Agos	de					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 16572 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Thelma A. Leadmon May  $1\overline{4}$ 2005 6:25 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 600 Annabel Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye Oct. 28, 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) Year 1909 **Funeral** Days 1 □ M 2 □ F 236 38 1442 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mudical Evandrar must be notified at 1 XYes 2 No **Baltimore** Director N/AMaryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. 21225 600 Annabel Avenue death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, Ite Madical Example and once. Anned Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd College (1-4or 5+) Self employed Resturant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fanna Bailey John E. McCormick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 Rosemary Kinder / Daughter 600 Annabel Avenue Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem 5/17/2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 namualle 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sagrantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 X No 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law 1 ☐ Yes certificate the Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner Other: Hospital: 4 ☐ Nursing Home 5 ▶ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 2**2**No 1 🗌 Yes 1 Inpatient this 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation 1 Natural 1 □ Yes 2 □ No after death. Director: Af 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1610 3040 address of person who completed cause of death (Item 23a) (Type, Print) 00 WITCHIMETON WINGTON 3 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 7 2005 Registrar

		1	For State Registrar	State of M	aryland		artment of F			giene	5	6573	
	Physicia /Medic	ın	1. Decedent's Name (First, Middle,	Last) ₩ ·	Li	psit	43		2. Date of Dea Month		Year	3. Time of Death	•
	Examin	er	4a. Facility Name (If not institution,  Meyer  5. Social Security Number	edical (	r)  6  ON  Age (In yrs. las	st birthday)	Baldy If Under 1 Year	r Location of Death  If Under 24 Hrs.		4c. County	9. Birthpla	ice (State or Foreign	_
	Director		212-30-5114 Usual Residence of Decedent	1 € M 2 □ F	74	Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day MAR. 7, I	931	Countr	MD d. Inside City Limits	_
	he Marylar 28a-f show		MD 10b. County	A	Toc. City,	BALT:				10g. Citizen of V		1 Yes 2 □ No	
	death with t	ral Di	10e. Street and Number 6701 PARK HEIG 11. Marital Status	12. Was Deceder	nt Ever in U.S.	. 13.	Was Decedent of H	21215			e - America	USA n Indian,	
0036	hours after ural', or Ita	P	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give Year or Dates	] No		1 ☐ Yes 2 💢 No	Specify:	o rican, etc.)	Specify		WHITE	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Uthar than. attural; or Itama 23a or 28a-f show ent, the Mysted Examiner must be notified a	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	College (1-40	r 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire ET ANALYS	during most of wor d)	rking	N.S.A.	usiness/indi		
Maryland	ould be fite I Mental Hy, tarkad oths	To Be C	17. Father's Name (First, Middle, L			LIPS	ITZ ng Address (Street	BEATRI				WEIS	
	s 1 and 2 sh f Health and item 27 Is m othar traum		19a. Informant's Name/Relationsh ROCHELLE LIPSI 20a. Method of Disposition	TZ / WIFE	20b. Pla	6701	PARK HEI  position (Name of matory or other pla	GHTS AVE			IMORE	, MD 2121	5
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a f show any injury or other traumatic event, II's Marical Examiner must be notified all once.		1  Burial 2  □ Cremation 4  □ Donation 5  □ Other (Sp  21. Signature of Funeral Service)	ecify)		B SHA	LOM MEMOF 2. Name and Addre 900 REIST	RIAL 05/1 ess of Facility S0	L LEVINS		OS.,	INC.	-
The state of the s	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or on shock, or heart failure. List of limited the condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (or b.	as a conseque	Do not en		ng, such as cardia		rrest,		Approximate Interval Between Onset and Death	15
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.O. Box 6	death certif le attending ad for use as	Physiclan/Medlcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal of dea	death 3[	□Ectopic pregnand □ Other (specify) _	у			ate of deliver	ry Day Year	
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Division of Vital	Attanding Physiclan: Threath. r death. actor: After this certificate by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Autural 5 Pending investig  3 Suicide 6 Could n	ation	njury Day Year)	28b. Time o Injury	of 28c. Inju	her: 4 Nursing I		dence 6 □Oti how injury occu	rred		
Divi			4 Homicide determi	200. Place 01	etc. (Specify)	}	th occurred at the t	ime date and plac	City or To				
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	Medical	(Check only one)  2 Medical E	xaminer: On the basis	s of examinati stated.	on and/or in	nvestigation, in my 29c. Licen	opinion, death occ se number	surred at the time,	date and place, 29d. Date signs	, and due to ed (Month, L	the cause(s)  Day, Year)	
,			30. Name and address of person of	who completed cause of	Ly V	<b>D</b> 23a) (Type	Print)	10744		may	15/2	2005	
2	Sta		K.A. Koricky 31. Date filed (Month, Day, Year)	Merc 32. Pgs	y New istrar's Signati	dicer	Print) Cewler	301 8	to Pour	e Plan	e H	D ZIZOZ	L
	Regist	ar	MAY 1	7 2005	RUSI 1	U. 1	2340						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 13, 2005 12:10 a<sup>™</sup> Dorothy La Moore 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days 1 □ M 2 🛣 F Yrs. Maryland October 6, 1943 212-42-9603 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2X No Randallstown Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21133 3807 Green Ash Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: African-1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☑ Divorced Americian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Assembly Worker 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Fellomay Blanchard Alexander Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Son) 3807 Green Ash Court, Randallstown, MD 21133 Michael Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery May 17, 2005 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLoring Byers Funeral Directors, 21. Signature of Funeral Service Licensee 23a. P. of 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Rd., Randallstown, MD 21133-4784 Onset and Death Breast rears Due to (or as a consequence of): Due to (or as a consequence of)

Month

Day

3 ☐ Probably 4 ☐Unknown

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Year

Physician /Medical Examiner

use as the burial-transit

attending for use as

detached

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryls Department of Heelth and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Iteme 23a or 28e-f ehow any Injury or other treumatic evant, the Medical Examinar must be tradified at ORGE.

Maryland 21215-0036

Examiner by Physician/Medical Be Completed Certification; To s effer des...rel Director: Aff

(Check only

Hospital or Attending Physicien: The lew requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 🗆 No 24a. Was an 1 ☐ Yes 2 (X)0 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 6 Ad ther (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Watural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

24 hours e To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier 3005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nates St Baltine MD State Registrar

			For State	State of Ma	aryland /	Depa	artment of H	lealth and		giene Reg. No.	005	16575
			Registrar  1. Decedent's Name (First, Middle, Las	st)			timouto or i		2. Date of De	ath		3. Time of Death
	Physicia				ovelea		Ma	tthews	Month	13	2cc5	2325 M
	/Medic Examin		Reba 4a. Facility Name (If not institution, give		Overe	111	4b. City, Town, or				ounty of Death	1
	Examin	er	SINAL HUSPITH		TIMORE		BALTIM	GRE CIT	4			
	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last b	irthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th Voor	9. Birth	place (State or Foreign untry)
	Director		219-26-8747	□M 2 <b>X</b> F	66	Yrs.	Months Days	Hours Min			8	MD
	P		Usual Residence of Decedent		40- Oit. T-							10d Inside City Limite
	aryla	_	10a. State 10b. County		Balti							10d. Inside City Limits  1,□,Yes 2 □ No
	18e-1	Director	MD NA		Dait.	LINOI				10- Citina	n of What Cou	
	with ti		10e. Street and Number				10f. Zip Code					antry?
	es 23	Funerai	2105 Crimea Ro	ad Apt 4		13 \	212 Was Decedent of H		Specify Yes or No		S A A	ican Indian
_	Item	Ľ.	1 ☐ Never Married 2 ☐ Married	Armed Forces?		10.1	f Yes, specify Cuba	in, Mexican, Pue	no Rican, etc.)		Black, White	, etc.
2	urs a	by	3 ☐ Widowed <b>X</b> Divorced	1 □ Yes 2 1 1 If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀 No	Specify:		S	ecify:	Black
Ž	filed within 72 hours after death with the Maryland Hygiene. yther then "naturel", or Items 23a or 28e-f ehow ant, the Medical Exarchart wat be neithfield at	ted	15. Decedent's Ed (Specify only highest gra	ducation	16	a. Deced	dent's Usual Occup	ation	rkina	16b. Kind	of Business/I	ndustry
2	thin 7 en "n	pie	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	kind of work done of DO NOT use retired	t)	nkuig			
7	filed within Hygiene. other then	Completed	12th grade	2yrs		Day	Care T			<u> </u>	ay Ca	re
	m - 0 5	Be (	17. Father's Name (First, Middle, Last)						me (First, Middle		ımame)	
Maryland 21215-0036		ို	Jordan Hardawa						lius Fo			
ā	2 2 2		19a. Informant's Name/Relationship (	Type, Print)	1		ng Address (Street			_		
	ss 1 and of Health item 27 other tr		Calvin Matthew 20a. Method of Disposition	s-Son			Loch Ra	ven Bl	vd, Ba.		re, M	
Š	0 0 -		XXBurial 2 ☐ Cremation 3 ☐		cemet	ery, crer	natory or other plac	1				
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Bervice Licer		King		norial E		20/05	Rand	alist	own, Md
Ba	permit. Departr Importa any inji		17/1	K-9-		Ma	arch F/E	1 West	D = 1 + :		M -2	21215
			23a. Part1. Enter the disease, or com	plications the caused	the death. Do	not ent	300 Waba er the mode of dyin	asn Ave ig, such as cardia	c or respiratory a	rrest,	MO	21215 Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.	_						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		a cons		bolism					2 days
	Examiner			1 km 50	nall Co		Lune Can	SCEP.			J.	Fine
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequenc		29 0	- C 60				. 7,3
	cuted od ransit	Examiner	that initiated events	С.								
o,	e exeran ar		resulting in death) Last	Due to (or as	a consequenc	e of):						
8760	icate be executed physician and s the burial-transit	dicai	•	d	<u> </u>							
9	artifica ing pl e as t	0	IF FEMALE:	00 1/								
Box	leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal dea		Ectopic pregnancy	,		230	<li>d. Date of delimental delimen</li>	very Day Year
O	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death	5	Other (specify)					
٥.	that the de led by the a detached	Ph	Part II. Other significant conditions of	contributing to death b	out not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Records,	w requires that been signed I should be det	Completed by	Pulmana he	nateri	24				1 🗀	Yes 2	No 3 <b>⊠</b> Pro	obably 4 Unknown
Ö	v requ	ete	66200	<del></del>					24a. Wa	s an	24b. Were au	topsy findings available
Re	has has	dw	COPU						auto perf	omed?	prior to c death?	ompletion of cause of
	icien: Th certificate rector, pag	e Co	25. Was case referred to medical					26 Place of Dr	1 ☐ Yes eath (Check only	2 X No	1 ∐ Yes	2 K No
<b>=</b>	ysicien: The is certificate hadirector, page	o B	examiner? 1 ☐ Yes 2 🗶 No	Hospital:	ent 2 ER/	Outpatier	nt 3 DOA Oth	A.F.	Home 5 ☐ Res		Other (Spec	cify)
Division of Vital	g Phys er this eral di	I -	27. Manner of Death	28a. Date of Inju	ıry 28b	. Time o		y at	28d. Describe			,,
<u></u>	nding th. r: Afte	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Da n	y rear)	Injury		Yes 2□No				
N	Atte	ertification;	3 Suicide 6 Could not b	286. Place of In	jury · At home, tc. (Specify)	farm, st	reet, factory, office		28f. Location City or To	(Street and I	Vumber or Ru	ral Route Number,
	s afte	Cert		banding, o								
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Example 1997)	nysician: To the best miner: On the basis of	of my knowled	ge, deat	h occurred at the tir	me, date and place	e, and due to the	cause(s) and p	nd manner as lace, and due	stated. to the cause(s)
	the H nin 24 the F nplete	Medi	one)	and manner st	ated.		20a Linone	o number		29d Date	signed (Month	
	To Con	2	29b. Signature and title of certifier	MID	)		DE C	5_ /7/1 /A		MAY	13,24	
	0-		- Linapar	. , , ,			NE.	)-000				
	8		30. Name and address of person who Hary Bashan	completed cause of	death (Item 23a	(Type,	ospital	of B	Baltim	0/2		
	Sta	ite	31. Date filed (Month. Day, Year)	32/Regist	rar's Signature	. / /						
	Regist		MAY 1 7 2	005	U. K	La	29c. Licens RE					
_		_				w #						

DHMH 17 Rev 1/2001

_			1 - For State of Maryland / Dep Registrar Ce	artment of Health and M rtificate of Death		ene 0 0 5	16576
	Dhusiai		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Stephen Derome Miller		0.5	10 200	5 620 P. M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
			Union Memorial Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Baltimore    Hounder 1 Year   Hounder 24 Hrs.	8. Date of Birth	N/A	theless (Ctate or Foreign
	Funeral Director		218-88-4581	Months Days Hours Min.	(Month, Day,	Year) 9. Bill 1965	thplace (State or Foreign buntry) MD
	ow ow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Many If sh	ţō	MD N/A Baltim	ore			1 <b>x</b> Yes 2 □ No
	h the	lrec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?
	23a c	alD	3025 Mayfield Avenue	21213		USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Exarting Trist be neitlined at once.	by Funeral Director	11. Marital Status  1 □ Never Married  2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: E	
21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	dent's Usual Occupation e kind of work done during most of workii DO NOT use retired)	ng 1	6b. Kind of Business	/Industry
7	e filed within al Hygiene. I other than " vent, Ine Ma	Con	12th N/A Car	penter		self-emplo	yed
land	uld be fill fental Hy rked oth iic even	To Be	17. Father's Name (First, Middle, Last)  Theodore Miller	18. Mother's Name	(First, Middle, M Gre		
Maryland	nd 2 should bith and N 27 is mai			ing Address (Street and Number or Rura 5 Mayfield Avenue I			Zip Code) .213
altimore,	ages 1 au ant of Hee nt: If item y or othe		1 2 Burial 2 Li Cremation 3 Li Removal from State I	matory or other place)	100	Oc. Location - City or Baltimore	
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee	2. Name and Address of Facility MAI	RCH FUNE	RAL HOME-E	CAST
		-	23a. Part1. Enter the disease, or complications that caused the death. Do not en	1101 E. North Avent			21202 Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Sepsis				Interval Between Onset and Death Z Day S
ì	Examiner	70	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):  ###################################				2 months
7	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	Tuberculosis			3 weeks
8760,	icate be executed physician and s the burial-transit	lical E	d				
P.O. Box 6	death certif e ettending id for use a	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
	uires that the signed by	þ	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
of Vital Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed			24a. Was an autopsy perform 1 Yes 2	prior to	atopsy findings available completion of cause of
ita		Bec	25. Was case referred to medical	26. Place of Death			
<u>_</u>	Z S D	2	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing Hor	ne 5 🗆 Resider	nce 6 Other (Spe	cify)
0	ng Ph Iter thi		27. Manner of Death Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Injury	of 28c. Injury at Work?	28d. Describe how	w injury occurred	
Sio	ttendi death. ctor: A y the fu	catl	2 Accident investigation	M 1 Yes 2 No			
Division	I or Attending I after death. Director: After I in by the funer	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	pital burs a erai (		29a. Certifier Certifying Physicien: To the best of my knowledge, dea	th congress at the time data and also	and due to the	120/c) and ======	etatod
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical					
)	with Con	Σ	29b. Signature and title of certifier  CBOLLND	um P1875	o $0$	d. Date signed (Mont	os s
	9		30. Name and address of person who completed cause of death (Item 23a) (Type ChandaBlee MO 201 Eart Un	Print) i Versity Parkwa	Balti	more Mau	land
	Sta Registr		31. Date filed (MATA) Day, Year) 005	29c. License number  29c. License number  UM P 1875  Print)  Versity Parkway			

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	ertificate of l		, ,	iene 0 0 E	5 16577
		<b>9</b>	1. Decedent's Name (First, Middle,	Last)				2. Date of Deat		3. Time of Death
	Physici /Medic		James	s Kenn	eth McI	ntyre		5 14	2005	7:26a. M
	Examin	er	4a. Facility Name (If not institution,	give street and number	)		r Location of Death		4c. County of	
			Gilchrist  5. Social Security Number	S. Sex 7. A	ge (In yrs. last birthda)	Towson	If Under 24 Hrs.	8. Date of Birth	Balti	More  Birthplace (State or Foreign
	Funeral Director		213-30-5798	1 <b>☑</b> M 2 □ F	70 Yrs. last biltida)	Months Days	Hours Min.	(Month, Day,	1935	Country)
			Usual Residence of Decedent		70			1 29	1935	MD
	show		MD 10b. County	/n	10c. City, Town or I					10d. Inside City Limits
	8a-fs	Director		A	Bartino					1 XYes 2 No
	with the		10e. Street and Number	J 7		10f. Zip Code	1220	10	0g. Citizen of Wha	at Country?
	eath	Funeral	1313 Glenwood	12. Was Deceden	t Ever in U.S. 13		L239 Ispanic Origin? (Sp	ecify Yes or No-	USA 14. Race	American Indian,
و	be filed within 72 hours after death with the Maryland lal Hygiene. d other then "naturel", or Items 23e or 28e-f show event, the Medical Exert art ast be redified at		1 Never Married 2 Marrie	Armed Forces	?  No	. Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 ☑ No	an, Mexican, Puerto	Rican, etc.)		White, etc.
003	urel'.	d by	3 ₩ Widowed 4 □ Divorced	Year or Dates:						Black
15	"nat	Completed	15. Decedent's (Specify only highest	grade completed)	(Giv	edent's Usual Occup: e kind of work done o DO NOT use retired	during most of work	ing	16b. Kind of Busin	ness/Industry
12	l withi	dwo	Elementary/Secondary (0-12)  12th	College (1-4or	5+)	l carrier	7		U.S. Pos	t Office
þ	e filed within al Hygiene. I other then ' vent, the Me	Be C	17. Father's Name (First, Middle, L.				18. Mother's Nam			
Maryland 21215-0036	2 should be f and Mental I is marked of reumatic eve	To E	David Mc	Intyre			Mary	Jess	up	
Mar	and and is m		19a. Informant's Name/Relationshi			ling Address (Street			•	
	1 an Heal		Jason McIntyre-s 20a. Method of Disposition	son	L31 20b. Place of Disp	3 Glenwood			e, MD 20c. Location - Cit	21239
Baltimore,	of H		1 ⊈Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Special Control of the Contr		cemetery, cr	ematory or other place n Forest \	γA 5/2		Owings M	
Ē			21. Signature of Funeral Service Li			22. Name and Addres	ss of Facility MA			
ä	permit. Departr Importe eny inju		> & lad	m w		1101 E. No				
1			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cause nly one cause on each	ed the death. Do not e line.	nter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
B	Pnysician		Immediate Cause (Final disease or condition	. ~	ie tastaha	canc	29			Onset and Death  Month's
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):					
	٥,	į.	Sequentially list conditions,	b. Due to (or a	s a consequence of):					
V	uted 1 ansit	Examiner	if any, leading to immediate cause. Enter Underlying		- u - u - u - u - u - u - u - u - u - u					
ó,	cate be executed obysician and the burial-transit		that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					=
8760,	ate be nysicia he bu	dical	1	d.						
9	artifica ing ph e as t	Med	IF FEMALE:							
Box	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy	,		23d. Date o Month	,
	The law requires that the death centificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of death 5	Other (specify)				
P.O	that I	y Ph	Part II, Other significant condition	s contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did tob	pacco use contribu	ite to the cause of death?
Vital Records,	w requires been sign should be	ed by	colon cano	e, blad	ider ca	nav		1 □ Ye	es 2021 No 3[	☐ Probably 4 ☐Unknown
000	law reas bee	Completed						24a. Was ar	n 24b. Wei	re autopsy findings available
R	The la ate ha page 2	mo						autops perform 1 Yes 2	ned?   dea	r to completion of cause of th? Yes 2□ No
/ita	sicien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	1			26. Place of Deat	h (Check only one		
of V	Physicien: this certific	은	1 ☐ Yes 2 No	Hospital: 1  Inpat			er: 4 Nursing Ho	ome 5 Reside	ence 6 Other	(Specify) Hospice
	ling After fune	ion	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, D	lay Year) 28b. Time Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	ow injury occurred	
Division	deal deal	ficat	2 Accident investiga 3 Suicide 6 Could no	t be 280 Place of Ir	njury - At home, farm, s		165 2   140	28f. Location (Str	reet and Number	or Rural Route Number,
Div	- 0 -	Certification:	4 Homicide determin	building, e	etc. (Specify)			City or Town		
	To the Hospital or within 24 hours afte To the Funerel Dire completely filled in the Funerel Direction of the Funerel Dir	Medical C	29a. Certifier Certifying (Check only one)	Physician: To the bes kaminer: On the basis and manner s	of examination and/or	ath occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manna ate and place, and	er as stated. I due to the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier			29c. License	e number	25	9d. Date signed (A	Month, Day, Year)
}	14.		Jeleyn	400		000	051921	0	May 1	4,2005
	HJ.			no completed cause of	NO			601 N. Cowson, M	Charles S	Street
:	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7	2005 37 Regis	trar's Signature	O. C.				

5/14/05 734 MCIntgre, James.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5 McCall 11 2005 1:a Codell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days 1 X M 2 □ F Yrs 249-14-6643 Director 87 8-31-17 S.C. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at ¶ Yes 2 No Md. NA Baltimore Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 813 E. 33rd St. 21218 Items 23a death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 ie marked other than "natural", or fte 1 ☐ Never Married 2 ☑ Married 21215-0036 Specify: 1 ☐ Yes 2 X No Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Danny's Restaurant 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Sinamae McCall Harry 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8792 Cloudleap Ct., Columbia , Md. Lorretta Avery DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or oth 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Mem. Park 5-16-05 Arbutus , Md. \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service License 1101 E. North Ave. March F.H. East Mes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner resilient 2m Sequentially list conditions, if any, leading to immediate Due to to as a consequence of) Examiner if any, leading to immedicause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ŏ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy 2 No 1 Yes 2 1 No Yes or Attending Physicien: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 🗀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 VER/Outpatient Certification: To 3 DOA 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t pellil Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOUNT DARSHAN 600 W. 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAY 1 7 2005 Registrar

DHMH 17 Rev 1/200

		,	1 - State Amend In	State o t <b>en 1 pe</b>	of Maryla	nd / Dep 3855,05	admen Hincat	ad H	ealth a Death	and M	ental Hyg	jiene	05	16579
	Discosiosi		1. Decedent's Name (First, Middle,	Last) Jose	phine	McCoro	l Sa	mpso	n		2. Date of Dea Month	th Day	Year	3. Time of Death
П	Physicia /Medic		JOSEPHINE	McCo	RA						5	11	700	
	Examin	er	4a. Facility Name (If not institution, g			F . 7	4b. City,		Location o				ounty of Deat	
			JOHNS HOPK  5. Social Security Number 6	. Sex	7 Age (In VI	s. last birthday,	If Under	,	7 MO		8 Date of Birth			· · · · · · · · · · · · · · · · · · ·
	Funeral Director		166-28-2140	1□M <b>¾</b> □F	69	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 3-13-		Co	hplace (State or Foreign untry)  N.C.
	ס		Usual Residence of Decedent								<u> </u>			
	arylar show	Ļ	10a. State 10b. County		10c. 6	City, Town or L								10d. Inside City Limits 11X Yes 2 □ No
	Se-f	Director		<u> </u>		Balt:	imore	0-4-						
	with t a or 2 be n	급	10e. Street and Number 3416 Mayfield	Δτιο			10f. Zip	2121	3			i Ug. Citizei	n of What Co USA	ountry?
	within 72 hours after death with the Maryland liene. Ithan "natural", or Items 23a or 28e-f show the Medical Examinar must be notified at	Funerai	11. Marital Status	12. Was Dec	cedent Ever in	U.S. 13.	Was Deced			gin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Ame	rican Indian,
20	after o		1 Never Married 2 Married		2 <b>∑</b> No						Rican, etc.)		Black, White	e, etc.
1215-0036	ral', c	d b	3 X Widowed 4 □ Divorced	If Yes, G Year or I	Dates:		1□ Yes	2 (A) NO	Specify:			Sp	pecify: B	lack
<del>ئ</del>	72 h	Completed	15. Decedent's (Specify only highest		)	16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	tion <i>uring m</i> osi	t of workii	ng	16b. Kind	of Business/	Industry
	filed within Hyglene. Ither then " int, the Me	dm	Elementary/Secondary (0-12)	College	(1-4or 5+)		rse's		,			Chi	ldren	Home
7 0	Hys than	e Co	12th grade  17. Father's Name (First, Middle, La	est)		IVU.	rpe p	-	18. Mothe	er's Name	(First, Middle,			Home
Maryland 2	0 0 0 0	To B	Joseph		9	Smith			Da	isv			Ton	ev
ar∠	\$ 5 E E	-	19a. Informant's Name/Relationship	(Type, Print)			ng Address	(Street a		_	i Route Numbe	r, City or T		
Σ	and 2 lealth a m 27 is		Gladys Berry	Siste					Ave.	, Ba	ltimore	, Md.	212	213
ore			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3	□ Removal from		. Place of Disp cemetery, cre	osition (Nan matory or o	ne of ther place	e)	D	ate	20c. Loca	tion - City or	Town, State
Ĕ	Pages ment of ent: if it ury or o		14 □ Denation 5 □ Other (Spe		I	King Me	m. Pk.	•		5/21/	/2005	Rand	allstc	wn, Md.
Baltimore,	permit. Pag Department Importent: i any injury o once.		21. Signature of Funeral Service Li	201500 1.1.6	A ( )	_ /	2. Name an			-			, Md.	21202
	20 = 6 Q		July C	wau	WS 1		March			-	1101 E.	Nort	h Ave.	Approximate
п			23a. Parfl. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final											Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Clek	20NIC	OBST	RUG	1V€	11	ILM	ONARY	Di	SEASE	
	Examiner		V			equence or):	I VI Q I	5						DAYS.
		Jer	Sequentially list conditions if any, leading to immediate	U	(or as a cons									D/(/-,
/	cuted	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c.										
Ď,	ate be executed hysician and the burial-transit	Ex	resulting in death) Last	Due to	(or as a cons	equence of):								
8760	cate be executed physician and the burial-transit	dicai		d										
×	death certific e attending p od for use as		IF FEMALE:	23c If was or	utcome of preg	ID 2 DOW								
Box	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fe	etal death 3	□Ectopic pr □ Other (sp					230	d. Date of del Month	Day Year
o.	by the detached	nysic	1 □ Yes 2 ≥ No 9 □ Unknown	9☐ Unkr		1 000111 51		ec.iy)						
J	The law requires that the te has been signed by the vage 2 should be detached.	by Pr	Part II. Other significant condition	s contributing to	death but not r	esulting in the i	underlying c	ause give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
rds	w requires been sig should be										1 🖫 🗡	es 2 🗆 t	No 3□Pr	obably 4 Unknown
၀ ၀	aw re	piet									24a. Was a		24b. Were au	stopsy findings available completion of cause of
Vital Records,	: The law cate has I	Completed									autop: perfor	med? 2⊠No	death?	2 No
Ita	sicien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					-	26. Place	of Death	(Check only or			
0	Physic this co	2	1 ☐ Yes 2 ⊠ No			☐ ER/Outpatie			4 🗆 Nu		ne 5 Resid			cify)
ב	ding P h. After i funera	Certification:	27. Manner of Death 1. ■ Natural 5 □ Pending		e of Injury nth, Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe h	ow injury o	ccurred	
Division	Attendia death. ctor: A y the fu	cat	2 Accident investiga 3 Suicide 6 Could no	t be Oge Plac	o of Injuny - At	home, farm, st	M factor		/es 2 □		28f Location /S	treet and N	Vumber or Ri	ural Route Number.
2	i or Atten after deat Director: I in by the	ertif	4 Homicide determin	ed buik	ding, etc. (Spe	cify)	reet, lactory	, onice		1	City or Tow		· umber or rig	and reduce restricter,
	To the Hospitel or Attending Physicien: within 24 hours stler death. To the Funerel Director: After this certific completely filled in by the funeral director.			Physician: To th										
	ne Ho	edicai	(Check only 2 Medical Ex	caminer: On the and ma	basis of exami nner stated.	nation and/or in	nvestigation	in my op	inion, dea	th occurre	ed at the time, o	ate and pl	ace, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	- kl	7	112	290	. License	number	~				h, Day, Year)
	1		Kapil Po	avall	> /	0 0		33	,70	)4		5 -	11-	2005
	Y		30. Name and address of person w	no completed cau			Print)	PK	1 10 1	C	BAYI	11=	W	
			31 Date filed (Month Day Vocal	KAKH		OHNS			1 10-	> (	>/(/(	110		
	Sta Registr		31. Date filed (Month, Pay, Year)	2005	Hogistial's 319	nature	all.							

			For State Registrar		State o		nd / Depa		of H	eaith a		-	Hygie	_	05	16	580
	Dhusis		1. Decedent's Name (First, Mid	dle, Last)								2. Date of		Day	Yeer	3. Time	of Death
	Physici /Medi		Florence	Hu1	me	Miner						May	14,	2005	1 001	6:21	р
	Examir	ıer	4a. Facility Name (If not instituti							Location of				4c. County			
			Sunrise Assis 5. Social Security Number	ted 6. Sex		·	a last hirthday	Sil If Under 1	ver	Spri	ng	0.0	(5:4)	Mon	tgom	- 4	
	Funeral Director		062-14-0866		: ]м 2[ <b>x</b> F	7. Age (in yr. 89	s. last birthday) Yrs.		Days	Hours	Min.	8. Date of	h, Day, Y	1916	9. Birth Col	iplace (Stat untry) inois	e or Foreign
			Usual Residence of Decedent									100	1 9	1710		THOIS	
	rylan	_	10a. State 10b. Coun	У		10c. 0	City, Town or Lo										City Limits
	Ba-f s	cto		ntgo	mery		Silver									1X Y	es 2□No
	th with the 23a or 23	Funeral Director	10e. Street and Number 11621 New Hamp	shir	e Aven	ue		10f. Zip (	Code 0904	į.			100	unit Unit		<sub>intry?</sub> tates	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "naturel", or items 23a or 28a-f show event. The Mulicel Examinetry ust by nutilied at	by Fune	11. Marital Status  1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce	rried	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	rces? 2 ⊠ No e		Was Decede If Yes, speci 1 ☐ Yes 2	fy Cubar	n, Mexican	gin? (Spe , Puerto	ecify Yes o Rican, etc	or No-		ck, White	ican Indian, , etc. White	
ŏ	2 hou	ted	15. Decede	nt's Edu	cation		16a. Dece	dent's Usual	Occupa	ition			16	Sb. Kind of Bu	usiness/l	ndustry	
215	hin 7 B. Marin	Completed	(Specify only high Elementary/Secondary (0-12)		College (1	-4or 5+)	(Give	kind of work DO NOT use	k done d e retired)	lu <i>ring</i> most )	of worki	ng					
2	filed wit Hygiene Ithar tha	Con			+		Jo	b Cou	nsel	or				Cour	nsel:	ing	
nd	should be filed withir nd Mental Hygiene. marked othar than metic event, the M	Be (	17. Father's Name (First, Middle	, Last)										iden Sumam			
<u>y</u> la	outd Men Marke Metic	မှ	Stephen Hulm	-										ss Hul			
Mar	12 sh n and 7 is m		19a. Informant's Name/Relation Stephanie Koen			0.30								City or Town,			
<b>6</b>	1 and Health em 2 ther i		20a. Method of Disposition	<u>-g,</u>			Place of Dispo			BOOM		lve,	4	er Spi			20901
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other treumetic ev once.		1 ☐ Burial 2 Cremation '4 ☐ Donation 5 ☐ Other	3 □R Specify)	emoval from	State	cemetery, crer Chesape	natory or oth	her place			L7/05		Beltsv			
Ball	Departimon Important Information		21. Signature of Funeral Service	Ticense	90	m003	82 R	Name and	Addres	s of Facility	d Ca	cemat	ion	Servic	200		
	405 a d		Suplus Xo	Ku	um		9	<u>33 Gi</u> s	st A	venue	:_Si]	ver	Spri	ng, MI	20	910	
			23a. Part1. Enter the disease, shock, or heart failure. Lis	st only on	e cause on e	aused the de ach line.	ath. Do not ent	er the mode	of dying	, such as	cardiac c	r respirato	ory arrest	t,		Approxim Interval B Onset an	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			e Chron	ic Obs	stru	ctive	Pul	mona	ry D	isease	2		
١	Examiner			1	Due to (	or as a conse	equence of):										
		er	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Ь	Due to (	or as a conse	equence of):										
1	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b> .													
ó	exec an an rial-tr	Exa	resulting in death) Last	ľ		or as a conse	quence of):										
8760,	sate be executed physician and the burial-transit	icai		0		<u> </u>											
9	Attending Physicien: The law requires that the death certificate be executed redeath. The death contificate has been signed by the attending physician and ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	1					-								
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	2		rth 2 ☐ Fe	tal death 3	Ectopic pre						23d. Dat	e of deliv	ery Day	Year
o	ne de: the a hed f	/sic	1 ☐ Yes 2X No 9 ☐ Unknown		4□Pregn 9□Unkno	ant at time of	death 5□	Other (spe	cify)					19101	101	Day	1 bai
P.O.	es that the death certific Igned by the attending p be detached for use as	P.	Part II. Other significant condit	ions con	tributing to de	ath but not re	esulting in the w	derlying car	I SA CIVA	n in Part I		23e I	Did tobar	co use contr	ribute to	the cause of	f death?
ds,	sign d be	d by	•					.son,g	g.re				1 ☐ Yes			bably 4	
20	w require been sly should b	ete										_	-				
Rec	he lav s has ge 2	Completed										8	Mas an autopsy performe		prior to co death?	opsy finding ompletion of	cause of
Division of Vital Records,	iclen: The lav certificate has rector, page 2		25. Was case referred to medic	al I								1 🗆 Y	es 2			2 No	
<u>=</u>	rsicle s cert direct	To Be	examiner?	1	ospital:	npatient 2[	☐ ER/Outpatien	t 3 DOA	Othe	26. Place				e 6 Othe	or (C=00	4.1	
of	Phy eral c		27. Manner of Death			of Injury h, Day Year)	28b. Time of		c. Injury Work	at				injury occurr		ry)	
ion	nding ath. r: Afte e fun	atio	1 Natural 5 Pend 2 Accident inves	ing tigation	(MONE	n, Day Year)	Injury	М		? 'es 2 □ N	10						
Vis	Atte	tiff	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be	28e. Place	of Injury - At I	home, farm, str	et, factory,	office		2	28f. Locati	on (Stree	et and Numbe	ər or Rur.	al Route Nu	mber,
Ö	tai or rs afto ei Dii ed in	Certification:			Dallall							Oily Oi	10411, 0	nate/			
	To the Hospital or Attending Physiclen: The I within 24 House after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certify Medica	ing Phys I Examin	ician: To the er: On the ba and mann	sis of examir	nowledge, death nation and/or inv	occurred at estigation, in	t the time in my opi	e, date and inion, deat	i place, a	ind due to ed at the ti	the caus	e(s) and ma and place, a	nner as s ind due t	stated. o the cause	(s)
	ro th vithin ro th compl	Me	29b. Signature and title of certifi	er				29c.	License	number			29d.	Date signed	(Month,	Day, Year)	
	- > - 0		¥.13d	256	n			1	D 4	79	28			5/1	6/0	5	
	5		30. Name and address of person	n who co	mpleted cause	of death (Ite	em 23a) (Type,							- 1			
	15		Dr. B. D. Y. H				nn. Ave	•	ensi	ingto	а. М	D 20	850				
	Sta		31. Date filed (Month, Day, Year	-)	32. Re	oistrar's Sign	nature			9-2							
	Registr	ar	MAY 1	7 200	15 16	free .	KL	all i									
DHI	VIH 17 Rev 1/20	001				و سبي	ORIGINA										
							ORIGINA	i Im									

		1 - For Amend Item 8&9	State of Maryland / Depart per fh 6843 5-23-05 Certif	ment of Health and I Ltas icate of Death	Mental Hygier	2005   658
Physic /Medi		1. Decedent's Name (First, Middle, Last)	MOBUARY		2. Date of Death Month	Day Year 3. Time of Death
Examin Funeral Director		5. Social Security Number 6. Sex	17. Age (In yrs, last birthday)	BAL*II MORE Under 1 Year   If Under 24 Hrs. Onths   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea 4-9-1951	9. Birthplace (State or Foreign Country) South Carolina
with the Maryland a or 28a-f show	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Locati	more		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
36 after death or Items 23	by Funeral Director	1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces?  1  Yes 25 No If Yes 1	Decedent of Hispanic Origin? (S. s. specify Cuban, Mexican, Puert	pacify Yes or No-	Citizen of What Country?  14. Race - American Indian, Black, White, etc.  Specify: R
21215- ad within 72 rgiene. er than "na!	Completed b	15. Decedent's Educ (Specify only highest grade	completed) (Give kind	's Usual Occupation of work done during most of wor NOT use retired)  LSEWIFE	king 16b.	Kind of Business/Industry  Donestic
laryla 2 should and Men is marke	To Be (	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type)	19b. Mailing A	18. Mother's Nan Mark ddress (Street and Number or Ru	ne (First, Middle, Maid Ca ral Route Number, Cit	ymond
timore, t. Pages 1 and rument of Heal retant: If item 2 along or other		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	Mt. Zion	2 Marquet in (Name of pry or other place) emeter 5/2 ame and Address of Famility	te Ld. Too.	Location - City or Town, State
Bal permi Depar Impo		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	rations that caused the death. Do not enter the	165 Up Ut R	C. Balt or respiratory arrest,	O·MD 21212. Approximate Interval Between
Physician /Medical Examiner bhysician and the private and the purial-transit the purial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  LUFUS  Due to (or as a consequence of):  Lheuma foid with a consequence of):			Onset and Death ~ 2 years
BOX 6 death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		opic pregnancy her (specify)		23d. Date of delivery Month Day Year
ords, P.O requires that the een signed by th rould be detache	þ þ	Part II. Other significant conditions conf	ributing to death but not resulting in the under	lying cause given in Part I.		o use contribute to the cause of death?
I Rec	Completed				24a. Was an autopsy performed	
on of V ding Physic After this of funeral dire	ation; To Be	25. Was case referred to medical examiner?  1 Ves 2 No  27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Other	th (Check only one) ome 5 Residence 28d. Describe how in	
in Little	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
he Hospital in 24 hours a he Funeral i	Medical	29a. Certifier (Check only one)  1 Certifying Physical Certifying	cian: To the best of my knowledge, death oc- er: On the basis of examination and/or investi and manner stated.	gation, in my opinion, death occu	rred at the time, date a	and place, and due to the cause(s)
1	Σ	29b. Signature and title of pertifier	MD	29c. License number P18.600	29d. [	Date signed (Month, Day, Year)  Ay 14, 2005  nore, MD 21201
3		Jeffrey LIU, M	npleted cause of death (Item 23a) (Type, Prin	veene st.	Baltin	nove, MD 2/201
Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signature			

amend 1	pe	r Dr., 17 pe <b>m</b> e anend i	<b>ase Ty</b> ten#24	pe of Prin la, perver state of Ma	baI, ryland	Pack In	<b>delibi</b> 5/17/ artmen	05 1 nt of H	<b>TEnsu</b> lealth a	re Al and M	lental H	s Are	e () ()	ble.	1658
		Registrar  1. Decedent's Name (First, Mid	ldle, Last)			Cei	Titicat	e of l	Death		2. Date of [	Reg. No	0.	-	3. Time of Dea
Physicia		Glendon	Mande	stosh Mc							Month A	1 Da		Year	2304
/Medica Examine		4a. Facility Name (If not institut	ion, give stre	et and number)	into	sn -	4b. City,	Town, or	Location of	f Death			-	of Death	1
		Holy Cross	Hospit						Sprin	ng		Mo	ontgo	omery	
Funeral		5. Social Security Number	6. Sex	7. Age 2	(In yrs. la	st birthday) Yrs.	If Under Months	1 Year Days	If Under :	Min.		Day, Year		Cour	
Director	}	None Usual Residence of Decedent	A			113.			2	16	May 3	200	5	Mary	land
yland		10a. State 10b. Coun	ty		10c. City,	Town or Lo	cation		-					1	0d. Inside City Lir
ith the Marylar or 28a-f show	ţŏ	MD Prin	ice Geo	orges	Ri	verda	1e								1 <b>½</b> ∑Yes 2 [
h with the	al Director	10e. Street and Number 7869 Riverdal	e Road	d #303			10f. Zip	0784				10g. C	itizen of V USA	What Cour	ntry?
deet	Funeral	11. Marital Status	12.	Was Decedent E	ver in U.S	. 13. \	Vas Dece	dent of Hi	ispanic Orig	gin? (Spe	ecify Yes or N	No-		e - Americ	an Indian,
ours after rai', or its	۾	1 Never Married 2 Married 3 Widowed 4 Divorce	arried	1 ☐ Yes 2 [Ž] No If Yes, Give Year or Dates:	•		l □ Yes		Specify:	, 1 0510	riodii, etc.)			∞ B1a	
72 hours 'natural', dical Exa	etec	15. Decede (Specify only high	ent's Education	on ompleted)		16a. Deced	lent's Usua kind of wo	al Occupa	ation during most	of worki	ina	16b. F	Kind of Bu	usiness/In	dustry
	Completed	Elementary/Secondary (0-12 N/A	)	College (1-4or 5+	)	ilfe. L	N/A		during most  )						
s 1 and 2 should be filed within Heelth end Mental Hyglene. The marked other then other treumatic event, the Mental Heelth end Mental Covent, the Mental Coventy	To Be	17. Father's Name (First, Middle Glendon Maci	-	Mcintosh	1				18. Mothe		(First, Midd Dunn	lle, Maider	n Sumam	ne)	
2 sho		19a. Informant's Name/Relation		•			_				il Route Num				
C -= W -		LaCole Dunn/	Mother	<u></u>	20h Die				Rd.		New Nate	_		_	. 20784
2 8°= 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		oval from State	COI	ce of Disponence of the contract of the contra	natory or o	ther plac	·					City or To	
nit. Pe artmen ortent: Injury	1	<ul><li>4 □ Donation 5 □ Other</li><li>21. Signature of Funeral Service</li></ul>			wasi	ningto				5-16	-05 shall'			nd, N	
permit. Departm Importe ony Inju		21. Signature of Pulleral Service	e Licensee	. 00							Washin				
	+	23a. Part . Enterthe disease, shock or heart failure. Li	or complicati	ions that caused t	he death.										Approximate Interval Between
	Exam	Sequentially list conditions, if any, leading to immediate cause. First International Cause (Disease or injury that initiated events resulting in death) Last	b c d	Due to (or as a	conseque	Spo ince of):	nka: nea Lup	nem uš	s t	Ja)	Cervi	s/n	1 Em	Sa.	•
requires that the death certificate be een signed by the attending physicis hould be detached for use as the bu	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal d	eath 3	Ectopic pr Other (sp						23d. Date Mor	e of delive	ry Day Year
uires that		Part II. Other significant condi	tions contrib	uting to death but	not result	ing in the un	derlying c	ause give	n in Part I.		11.				e cause of death?
The law require ate has been slipage 2 should be	Completed										per	opsy formed?	8	rior to cor leath?	osy findings availa
ician: Th certificate rector, pag	0	25. Was case referred to medic	al						26. Place	of Death	1 Yes		1	Yes	∠L N0
ysicia is cert directe	n	examiner? 1 ☐ Yes 2 ☑ No	Hosp	oital:	2□€	R/Outpatient	3 🗆 DO	Othe			ne 5□Res		6 □Othe	er (Specifi	)
<u>≥</u> .≅ ₽	9			8a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury	2	8c. Injury Work	at ?	1	28d. Describe	how inju	ry occurr	ed	11
ng Physician: ter this certific neral director,	0 :::0	27. Manner of Death	lina 2	(Month, Day	- 1	,,	м		res 2∐N	lo					
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			1 - For State Registrar	State of Marylan		artment o			and M	-	giene Reg. No.	005	1658	3
	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Dea	ath Day	Yea	3. Time of De	
	/Media			rshall						May	04	2005	2:25	P M
	Examir	er	4a. Facility Name (If not institution, give st			4b. City, Tov						County of De		
	-		Washington Adventi  5. Social Security Number 6. Sex		last hirthday)	Tako		PArk,		9 Date of Rid		ontgom	ery inthplace (State or F	
	Funeral Director			7. Age (In yrs. 53	Yrs.		ays	Hours	Min.	8. Date of Birt (Month, Da lay 31	Year)		st Indes	breign
	P.		Usual Residence of Decedent						I				or maes	
	arylar show	_	10a. State 10b. County		y, Town or Lo								10d. Inside City L	
	Ba-f	Director	MD Montgomer	у Т	akoma								1 X Yes 2	
	with t	Ö	10e. Street and Number			10f. Zip Co					10g. Citiz	zen of What (	Country?	
	eath	Funeral	116 Lee Avenue #10	) 7 . Was Decedent Ever in U.	S 13 1	207		nanic Orio	rin2 (Sne	cify Yes or No-		SA A Bace - Am	nerican Indian,	
0	r Iter	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1	f Yes, specify	Cuban,	, Mexican	, Puerto F	Rican, etc.)		Black, Wh	nite, etc.	
<u> </u>	ral', c	d by	3 ☐ Widowed 4 🖾 Divorced	tf Yes, Give Year or Dates:		1⊡ Yes 2∏	No	Specify:				Specify: B	lack	
ر ک	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f ehow event, I'm Mudical Exer.in writinal be notified at	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced	dent's Usual O kind of work o DO NOT use n	ccupat lone du	ion iring most	of workin	lg	16b. Kir	d of Busines	s/Industry	
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an	should be bd Mental markad o imatic eve	To Be	Shirley MArshall						s Co			,		
Maryland 21215-0036	2 should and Men Is marka	_	19a. Informant's Name/Relationship (Type							Route Numbe				
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Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei	noval from State	lace of Dispo emetery, cren	sition <i>(Name o</i> natory or other	of r place)	)	Da	ate	20c. Loc	eation - City o	r Town, State	
			'4 □Donation 5 □ Other (Specify)	Was		on Nati						and, N		
e H	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	20						shall's Washing				
			23a. Party Enter the disease, or complica	itions that caused the death								D.C.	Approximate	
	Physician		Immediate Cause (Finat	ause on each line.	Q V	nv	C /	17/	1.	2			Intervat Betwee Onset and Deal	n th
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	70	0	20	7 0	90	r) t	-020	7104	
	Examiner		Sequentially list conditions, if any, leading to immediate											
	ted isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):									
	execunand and all-train	xar	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):				-				1	
3/60	icate be executed physiclen and s the burial-transit	dicail	d.											
õ	certifical nding phy use as th	0	IS SELVE .											
X P P		an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	tf yes, outcome of pregnated the control of the co		Ectopic pregn	ancv				23	3d. Date of de		
5	the atten	Physician/M	1 Yes 2 No	4□Pregnant at time of de 9□Unknown	eath 5	Other (specif	y)					Month	Day Year	
7	that the ed by detac		Part II. Other significant conditions contr	buting to death but not resu	ulting in the ur	deriving cause	a diven	in Part I		23e Did to	hacco us	e contribute t	to the cause of death	2
ds,	w requires that the death been signed by the atte should be detached for	d by	3	Summy to doubt summer to su	in the di	idenying causi	5 giveii	iii raiti,			es 2		robably 4 Unkn	
ecord	law req as been 2 shou	lete								24a. Was a	10	24h Wara 2	utopsy findings avai	labla
~	0 - 0	Completed								autop: perfor	sy med <b>?</b>	prior to death?	completion of cause	of
	sician: The certificate rector, pag	O	25. Was case referred to medical				2	Place	of Death	1 ☐ Yes Check onl or	2 <b>17/N</b> 0	1 ☐ Ye	s 21/21No	
>	Physician: this certific ral director,	To B	examiner? 1 Tes 2 No Hos	spital: 1 🗆 Inpatient 2 🔏	ER/Outpatien	t 3□ DOA	Other:			e 5 Resid		Other (Spe	ecify)	
П ОІ	nding Physician: th. : After this certifica ? funeral director, p		27. Manner of D th 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	injury a Work?	ıt	28	8d. Describe h	ow intury	occurred		
<u> </u>	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be					s 2 N						
UIVISION	or At after of Direct in by	ertification;	4 Homicide determined	<ol> <li>Place of Injury - At ho building, etc. (Specify</li> </ol>	me, farm, stre	et, factory, off	ice		- 28	Bf. Location (S City or Tow	treet and n, State)	Number or R	Rural Route Number,	
_	spital ours neral filled	O	29a. Certifier 1™ Certifying Physic	ian: To the best of my know	wledge, death	occurred at th	ne time	date and	place ar	nd due to the c	auso/s) a	and manner a	e etated	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	edical	(Check only 2 Medical Examine one)	r: On the basis of examinat and manner stated.	ion and/or inv	estigation, in r	ny opin	nion, death	occurred	d at the time, d	ate and p	place, and du	e to the cause(s)	
	To the To the Comp	Ň	29b. Signature and title of continer	100.	· — · · ·	29c. Lic	ense r	number	. 1	2	9d. Date	signed (Mon	th, Day, Year)	
	9		1000	14716		T.	) L	ts	9	11	5	103	100	
	'		30. Name and address of person who com	oleted cause of death (Item	23а) (Турв, 1	Print)	1/K	sh,	110	1	1	Lhei	60121	
	Sta	e	31. Date filed (Month, Day, Year)	2. Registrar's Signat	ure .	<u> </u>	V (V.	2016	177	1027	M	0007	11 4500	17/
	Registra		MAY 1 7 2005	2. Registrar's Signat	4000									

State of Maryland / Department of Health and Mental Hygiene 0 0 5

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				Cen	rificate of	Death		Reg. No.		
П			Decedent's Name (First, Middle, Last)				2. Date of D	eath Dev	Voor	3. Time of Death
	Physicia		Charles Junest MANS				May		Year UUS	3:45 am
	/Medic		4a Facility Name (If not institution, give street end number)			4b. City, Town, or				10 /10.
J.	Examin	2	11 11							
	ė.		HARRER NURSING HUME	4 F ( 11 - 11 - 11 - 11 - 11 - 11 - 11 -	If Under 1 Year	BATH NOT	2.8	41	0.5:41.1	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	Yrs.	Months Days	Hours Min	, (Month, D	ey, Year)	Count	ace (State or Foreign
	Director		218 22 / 190 1 81	115.			Jeptem 6.	FR 6, 1923		M.D
	p.		Usuel Residence of Decedent		-4*					
	ryla Thow		10e. Stete 10b. County 10c. City, 1	Town or Loca	ation				10	d. Inside City Limits
	Ma	ğ	M.D NIA BA	14mon	E					1 Yes 2□ No
	128 101	<u>8</u>	10e. Street end Number		10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
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	filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or frams 23a or 28a-f show ent, the Modical Examiner must be notitied at	Funeral Director	TOU ADDICATED	12 W			Specify Voc or N		e - America	n Indian
	er d	S	Armed Forces?	/ IS. If	Yes, specify Cul	Hispenic Origin? (S ban, Mexican, Puer	rto Rican, etc.)	Blac	k, White, e	
20	eff of	by F	1 Never Married 2 Married 1 Yes 2 No NWE	1[	☐Yes 2√No	Specify:		Specify	11	
8	Jour Jan	9	3 ☐ Widowed 4 ☐ Divorced Year or Dates: /9 42 — /	945					Blac	
'n	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give ki	nt's Usuel Occu ind of work done	during most of wo	orking	16b. Kind of Bu	siness/Indu	ustry
21215-0020	F 8 6 Hz	0	Elementery/Secondary (0-12) College (1-4or 5+)	life. Do	O NOT use retire	9d)				
2	A Pier	5	9 0	PAIL	ce MAS	Unely		PRICK!	noscne	rng
Maryland	of ty	Be	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle	e, <i>Maiden</i> Su <i>rna</i> m		
ā	id be entel ked o	10	Albert MANNS			Thiseast	hine (	Ampson		
<u> </u>	should and Men marke umartic	-	19a. Informant's Name/Relationship (Type, Print)	19b Mailing	Address (Stree	at and Number or R	turel Route Numl	her City or Town	State Zin (	Code)
<u>8</u>	12s han risu			- /						
	end lealt	1	Clayfor Manns	7801	tion (Name of	een AVE				
5	of H		20a. Method of Disposition 20b. Plac	etery crema	story or other nic	ece)	Date	20c. Location -	-	
Ĕ	Peges nent of int: If its iry or o		4 □ Donation 5 □ Other (Specify)	150 N	Fonest	CEMETERY	5/18/05	Boston	now M	10
altimore,			21. Signature of Funeral Service Licensee	22.	Name and Addr	CEMETERY 13	201-		land	
ñ	permit. Departr Imports any Inje		Les Charles							
_			Sature But			PARULINE		ne MD o	112/3	
100			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter	the mode of dy	ing, such as cardia	c or respiratory	arrest,	( )	Approximate Interval Between
	Physician				r					Onset and Death
4	/Medical		Immediate Cause (Final disease or condition	15	150	0:4			-	
	Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or each)		anda ath:	1000			1	
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$\sqrt{}$	nsit	n/Medical Examiner	b. At 222		77 7 7 7 T					
	ocertificate be executed inding physician end use es the buriel-transit	Xa	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying		ence of):				1	
3	be e	<u>=</u>	cause. Enter Underlying Ceuse (Disease or injury that initiated events  Due to (or as	V	1244				İ	
68760,	ohys the	읗ㅣ	that initiated events pue to (or as resulting in death) Last	a conseque	ence of):				į	
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ŏ	th ce	2	. 1 11 2						-	
D	The law requires that the death site has been signed by the atterpage 2 should be deteched for	by Physicia	Part II. Other eignificant conditione contributing to death but not resulting	ng in the unc	lerlying cause g	iven in Part I.	23b. Did	tobacco use cor	tribute to	the ceuse of death?
Ö	the sche	ڄ			,,			Yee 2□ No	1	ably 4 Unknown
<u>.</u>	that that det	<b>P</b>	James Deuster	~				100 2010	5/4.100	ably 4 officion.
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r	The te h	5					10	Yas 2000	1 🗆	Yes 2□ No
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5	Phys this rald	Ĕŀ		VOutpatient 3b. Time of	3□ DOA 28c. Inju	4 Valursing i	-	how injury occurr		
5	ing i	ᡖ	1 Deviatural 5 Pending (Month, Dev Year)	Injury	Wo	ork?	Zod. Describe	now injury occur	60	
Division of Vital Records, P.O.	Attanding Physician: ar death. actor: After this certific by the funeral director.	g	2 ☐ Accident investigetion 3 ☐ Suicide 6 ☐ Could not be		M 1	Yes 2□No				
Ë	er d ract	\$	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	et, factory, office		28f. Location City or To	(Street and Numb own, Stete)	er or Rural	Route Number,
<u> </u>	s efficiency	Ö								
	hour hour ners y fill	<u> </u>	29a. Certifier 1 Certifying Physicien: To the best of my knowle	dge, death o	occurred at the t	ime, date and place	e, end due to the	cause(s) and ma	nner as sta	ited.
	To the Hospital or Attanding Physician: The I within 24 hours effer death.  To the Funeral Diractor: After this certificete hat completely filled in by the funeral director, page	edical Certification: To	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or inve	stigation, in my	opinion, death occ	urred at the time	, date and place, a	and due to t	tne cause(s)
	om this	ž	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed	(Month, D	lay, Yeer)
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	Λ		9			24276	>	7.1	2-01	
	1		30. Name and address of person who completed cause of deeth (Item 23	4	0		. 1	. 4		
	į.		Simon Scalia 2801 H	uds	on S	it Ba	Ho. M	ld, 21	224	
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrer's Signature	9						
	Registra	r	MAY 1 7 2005 Red	-	A9 0					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 09:00 M Ethel M. McCarty Mae 1005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 1227 W. 37th Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 26, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 ☐ M 2 📆 🕌 83 Yrs 214-12-8792 Maryland Aug. 1921 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "neturel", or Items 23a or 28a-f show event, the Medical Examiner must be notified at XX Yes 2 No Baltimore Maryland N/A Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21211 USA 1227 W. 37th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter Hygiene. 1 ☐ Yes 2x☐xNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No þ Specify: white 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Importent: If item 27 is marked other thi any injury or other treumatic event, Ing. Once. In own home Homemaker 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Viola Cameron Amos Sentz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) New Freedom, PA 155 East High Street Steve McCarty Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 5/13/2005 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Vicenses 22. Name and Address of Facility
Burree—Henss—Seitz Funeral Home, Inc.
3031 Falls Koad Baltimore, Maryland 21211 n er the disea e or o m or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stati 3 grs /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Dire to (or as a nonsequence of) d any, leading to infined cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2 No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ be 3 ☐ Probably 4 ☐ Unknown 2 **X** No 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No 1 Yes 2 No certificate 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔣 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No P this 28a. Date of Injury (Month, Day Year) uneral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: within 24 hours after death. To the Funerel Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No M in by the 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🖪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Plarler cause of death (Item 23a) (Type, Print) Paven Blod 560 uantes 31. Date filed (Month, Day, Year) State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year MOLBOGOT ZELDA May 1225 /Medical 14 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai Hospital of Bultimore Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) MAR. 21, 1922 Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2□F 83 Yrs. 116-14-2429 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Example; must be notified at 10d. Inside City Limits Director BALTIMORE 1 ☐ Yes 2 No OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9403 PLAINE TREE CIRCLE #105 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Completed by Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H **JOSEPH** KLEIN ၉ ROSE DEUTSCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, ortant: If item 27 is vinjury or oth SAMUEL MOLBOGOT / HUSBAND 9403 PLAINE TREE CIRCLE #105 - OWINGS MILLS, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 14 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW CEM. 05/15/2005 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee durana 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovanular accident /Medical Due to (or as a consequence of): **Examiner** myscardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence of) Examiner burial-transit The taw requires that the death certificate be executed consurtive Kea Due to (odas a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy łoł in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of prior to completion death? autonsy performed 1∐ Yes 2 Z No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA s after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 100 29c. License number 29d. Date signed (Month, Day, Year) RES-000 Calero MD May 14 2005 ON ress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar elian Valeno MD

Sinai Hospital of Baltimore

State of Maryland / Department of Health and Mental Hygiene 6588 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12, 1:25A BRODIST RAY NORTON, SR. MAY 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MILLENIUM HELTH & REHABILITATION FORESTVILLE PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. XXXM 2□F HOMER, Director 447 32 9145 69 23, 1935 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show the Medical Examiner must be notified at XX Yes 2 No Directo MARYLAND PRINCE GEORGES FORESTVILLE the 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number itams 23g 20747 UNITED STATES 6829 RED MAPLE COURT by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No 1954- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. e filed within 72 hours after al Hygiene. I other than "natural", or ital 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates: Specify: BLACK XXWidowed 4 Divorced 1969 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12TH ARTILLARY / AIRBORNE UNITED STATES ARMY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fit and Mental F is markad of SARAH TURNER ျှ CHESTER NORTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is rr any injury or other traum. BRODIST R. NORTON, JR. / SON 6829 RED MAPLE COURT FORESTVILLE, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN\_CREMATORY 5/17/05 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. JOHN 4308 SUITLAND ROAD SUITLAND, MD 20746 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASPIRATION PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached for ☐Yes 2☐No Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by SEIZURE DISORDER, DECUBITUS ULCER 1 Yes XX No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 200 No certificate 2□ No 1 ☐ Yes 1 ☐ Yes Division of Vital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 1 ☐ Yes XXNo Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 70 2 ER/Outpatient 3 DOA this After thi funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: XXNatural 5 Pending death. investigation 1 Yes 2 No Diractor: / 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide To the Hospital within 24 hours a XXX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier 5 D52900 MAY 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h 8700 CENTRAL AVE. #301 LANDOVER, MD 20785 MUSA MOMOH, M.D. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 7 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 16589 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 OsKay Janet /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MOR HEALTHCARE HGNES If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 X F Months Hours Min. Director 216-30-2200 NJUsual Residence of Deceder with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event. The Madical Examiner must be notified at 1 TYYes 2 □ No Director MD NA Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3813 Dorchester Road 21215 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Yes 2 XNo If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disability, 2th grade Team Leader Social Security Adh 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Sheldon Burke 2 Grace Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 sh Department of Haalth and Importent: if Item 27 ie rr any injury or other treum once. Vural OsKay-Husband 3813 Dorchester Road, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 5/18/05 Baltimore Co, Md 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Approximate Interval Between Onset and Death rediate Cause (Final **Physician** toni disease or condition resulting in death) day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ed by the ettending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed?
1 Yes 25 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 25. Was case referred to medical Be 26. Place of Death (Check only on examiner Other: 1 Tes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospitei or Attending After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitei c within 24 hours af To the Funerei D completely filled is Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 8203 MO D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Ca VENUR 101 Greer 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 7 2005 Registrar

			For State Registrar	State	of Maryla	and / Dep	artment rtificate			and M		giene Reg. No.	05	165	90
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	/Medic		Pierce E. Pot								May	14,	200		5 P M
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Maryland	d 2 st th and 7 Is n treun		19a. Informant's Name/Relationship Alisa B. Kobrine		ornev)						a <i>l Route Numb</i> Parkway	-		Md. 21	044
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Bo	attende for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	oirth 2 F	etal death 3	Ectopic pre Other (spe					2	3d. Date of Month	Day	Year
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Division of Vital Records, P.O.	es that the death cer igned by the attendin be detached for use	by PI	Part II. Other significant conditions	contributing to c	eath but not i	resulting in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco us	e contribute	e to the cause of	death?
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Ö	in the	Certification:	4 - Homicide	Build	ing, etc. (Spe	icity)					Only of 70	vii, State)			
	To the Hospitel or Attending Physicien: The law within Z4 burusr after death.  To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	edicai	(Check only 2 Medical Ex	Physician: To the	asis of exami	nowledge, death	n occurred a	t the time	e, date and inion, deat	d place,	and due to the ed at the time.	cause(s) a	and manner	as stated.	(s)
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i	1 w 1		29b. Signature and title of certifier	M-D.			236.	-		2-20			-	5 - 20	
	0		30. Name and address of person wh	, ,	e of death /II	tem 23a) (Tyne	Print)			/ 3					
	<u>'</u>		MALIKA	LASE	EM	. 7	09.	B	AST	EX	en B	LVD	- A1	D-212	-21.
	Sta Registr	_	31. Date filed (Month, Day, Year) 7	2005 32.	egistrar's Sig	matura.	cedi								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 15ton 14 mer 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 218-14-6700 Months Days Hours Min. 1 MM 2□ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Items 23a or 28a-f show 10b. County 10a State 10d. Inside City Limits 77 is marked other than "natural", or items 23a or 28a-f shov traumatic event. It a Marifeal Examiner must be multilled at saltimore 1 ☐ Yes 2 ☐ No Completed by Funeral Director and 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 211 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 2 Married 1 Never Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify. Blac 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) lec (First, Middle, (Last) (First, Middle, Maide To Be nnsor บท nonata itam 2 20b. Place of Disposition (Name of Acemetery, crematory or other place) Method of Disposition Department of H Important: If its any injury or ot once. Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) ature of Funeral Service Nice 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, any leader Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to for as a Physician/Medical Examiner and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-t Division of Vital Records, P.O. Box 68760. use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should 24a. Was an autopsy performed? 1 ☐ Yes 💢 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funaral Diractor: A
Completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete trause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

Madelles

111-6h

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yea Man Physician 5:30 am 2005 Pear1 Charles /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ST. AGNES BALI MUKC

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 24, 1 HEALTHCARE N/A 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1X M 2 ☐ F 1935 Maryland 69 Director 213-32-8445 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore 1 XYes 2 No N/A Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21223 235 S. Stricker St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "naturel", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Solo Cup Company Machine Operator 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Catherine **Blanche** Neagly Pear1 Calvin Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 S. Stricker St., Baltimore, MD 21223 Frances E. Pearl (Wife) or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 LTBurial 2 Cremation 3 Removal from State
4 Donation 5 Other Specify permit. Page Department of Importent: If any injury or once. Loudon Park Cemetery 5/14/05 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Sevice! 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death Farty-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if arry, leaving to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit erlin that initiated events resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) by the a ☐Yes 2☐No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Miknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy 1 Yes 2 DNO 2/2 No certificate or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ₩ 1 Thipatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28d. Describe how injury occurred Certification: ision 1 DNatural 5 Pending Injury 1 🗌 Yes 2 🗆 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) D⊠ 4 Homicide Hospitel 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060501 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 caton Ane 0414, M.D. Registrar's Signature MAY 1 7 2005 Registrar

			For State	State of Ma	-					nd Me	ntal Hyg	jiene (	05	16593
			Registra AMEND TTEM	#20B per fl	1 g843	5/2	4763 te	in De	eath		. Date of Dea	eg. No.		2 Time of Death
П	Physicia	an	Decedent's Name (First, Middle,	Lusty							Month	Day	Year	3. Time of Death  2030 M
	/Medic	al	Perry 4a. Fecility Name (If not institution,	Ke A	ndre		4b. City, To	bin:			lay		unty of Deatl	
	Examin	er	Th. 71 11	1. 11.	il.		0 11	1 .		C ?	10		,	,
•	Funeral	4		Sex 7. Age	(In yrs. last	birthday)	If Under 1	Year I	If Under 2		. Date of Birth	) Vone	9. Birti	nplace (State or Foreign
i.	Director		220-71-8105	<b>Ж</b> М 2□ F		Yrs.		Days	Hours	Min.	(Month, Day )4 18			MD
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Le	neation							10d. Inside City Limits
	shov	ក			,									1 X Yes 2 □ No
	the M	Director	MD NA  10e. Street and Number		Balt		10f. Zip C	Code				10a. Citizer	of What Co	untry?
	with Se or			λνο				212	15				J.S.A.	· ·
	ms 2%	Funeral	3026 Rosalind  11. Marital Status	12. Was Decedent E	ver in U.S.	13.	Was Decede			in? (Specif	fy Yes or No- can, etc.)		Race - Ame	rican Indian,
9	or Ita	Fur	XXNever Married 2 Marrie	Armed Forces?	o		ा res,spec⊪ 1 🗆 Yes 2√,		Specify:	Puerto Hit	can, etc.)		Black, White	a, etc.
21215-0036	ural",	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:									B.	Lack
2	"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	1	(Give	dent's Usual kind of work DO NOT use	done dur	on ring most (	of working		16b. Kind	of Business/	ndustry
12	withir ene. than	шc	Elementary/Secondary (0-12) N/A	College (1-4or 5+	-)		emplo	•				Un	empl	oved
0	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "natural", or Items 23c or 28s-f show svent, It a M. Jical Exstring in usi be notified at	Be Cc	17. Father's Name (First, Middle, La						8. Mother	's Name (/	First, Middle,			
<u>la</u>	should be filed withir nd Mental Hygiene. marked other than imatic svent, II a M	To B	Perry C. Rob	inson					Penn	y L	Bruns	son		
Maryland	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any Injury or other traumatic: once.	_	19a. Informant's Name/Relationshi		1	19b. Maili	ng Address (	Street and	d Number	or Rural F	Route Numbe	r, City or To	own, State, Z	ip Code)
	1 and 2 Health em 27		Penny L. Brun	son-Mother							Baltin			
altimore,	Pages 1 nent of H. int: If iter		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3	☐Removal from State	ceme	etery, crei	osition (Name matory or oth	ier place)		5/20°/			tion - City or	
≣	permit. Pag Department Important: any Injury c		`4 □Donation 5 □Other (Spe		Mt.		n Cen				<del>495</del> E	Balti	more	, Md
Ba	permi Depar Impo any Ir		21. Signature of Funeral Service Li	censee		M	larch	F/H	Wes	st	n 3 t 3		w 3	
			23a. Part 1. Enter the disease, or c shock, or heart failure. List of	omplications that caused	he death. [						Balti espiratory arr		Ma Ma	Approximate
	Discharian		shock, or heart failure. List or Immediate Cause (Final	nly one cause on each line	э.	$\supset$	1	1						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequen	ce of):	metur	144						Jule 15
	Examiner		Conversion, that are distance	, Over	Shelm	ning	Seps	iS						36 hours
N.	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequen	ce of): J	1							
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Vate	consequen	Duct	us A	tecu	2020					3 weeks
760,	The law requires that the death certificate be executed at the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit.	Ical E		200 10 (01 03 0	Consequen	00 017.								
687	ficate physics the	edlc	100	d										
X	eath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			□Ectopic pre					230	I. Date of deli	*
n n	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2			Other (spe						Month	Day Year
o.	at the by th	hys	9 🗆 Unknown	9□ Unknown										
_	res that the de signed by the a be detached f	by	Part II, Other significant condition	s contributing to death bu	t not resultin	ng in the u	inderlying cai	use given	in Part I.		23e. Did to	V		The cause of death?
Records,	w require been signal	Completed												
ec Sec	e law has b	mple									24a. Was a autop	sy	prior to death?	topsy findings available completion of cause of
											1 X Yes	2□No	1 🗆 Yes	2 No
Ĭ	siclar certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatier	# 2□EB	/Outpatie	nt 3 DOA				Check only on 5 ☐ Resid		Other (Spec	estv)
ō	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date of Injury (Month, Day	/ 28	b. Time o		c. Injury at Work?			d. Describe h			
0	Attending Ph ar death. ector: After th by the funeral	atlo	1 SNatural 5 ☐ Pending 2 ☐ Accident investiga	tion	( dai)	Injury	М		s 2 🗆 N	lo				
Division of Vital	t or Attending Physician: after death. Director: After this certifica in by the funeral director.	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			, farm, st	reet, factory,	office		28	f. Location (S City or Tow		lumber or Ru	ral Route Number,
	urs afi	O							4	1	4 4	/ :		and the desired
	Hosp 24 hou Fune Fune	edical		Physician: To the best o xaminer: On the basis of and manner stat	examination									
	To the Hospital or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier	and mailler stat			29c.	License n	number		- 2	29d. Date s	igned (Month	n, Day, Year)
			1 hunte	Hat ma	( 100	)	K	les-	000	)		May	12 .	2005
	3	-	30. Name and address of person w	ho completed cause of de	ath (Item 23	Ba) (Type,								
			TayoR	tolman m	D 60	N 00	1. WO1	fe s	Stree	et 1	baltin	nore	mi).	21287
1.0	Sta		31. Date filed (Month Ay. Year)	2005 Registra	r's Signature	do	ente)							
	Registr	ai		1-0	- 50	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12,2005 AINE 12:10 AM /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Samaritan HOSPITAI If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F JUNE 16, 1920 SOUTH CAROLINA Yrs. 105.22.8690 Director Usual Residence of Decedent 10d. Inside/City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show 1 Yes 2 □ No MD PACTIMORE Funeral Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 DNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married BLACK ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No þ 3 Widowed 4 ☐ Divorced "natural" Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College\_(1-4or 5+) HEALTH CARE permit. Pages 1 and 2 should be filed within Depertment of Heelth and Mental Hygiene. Importent: If item 27 is marked other than any injury or other traumatic event, Item 20nes. 18. Mother's Name (First, Middle, Maiden Sumame) SARAH WOODSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5109 ST. GEORGES AVE. BATIMOKE, MD 2/212 20a. Method of Disposition 2Qc. Location - City or Town, State Burial 2 Cremation PIKESVILLE, MARYLAND 10GE CEMETERY 5.1705 PIKESVILLE, MARYLAND 22. Name and Address of Pacility VAUGHN C. GREENE FUNERAL HOME ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** /Medical Due to (or as a consequence of): Examiner pirator Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): .O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Cerebrovascular Acadent 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 1 Ko 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 1 Inpatient Certification: To 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

2005

Nilgh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



Res 000

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, Examiner 4b. City, Town, or Location of Death 5. Social Security Number If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth 219-28-6301 72 Months Days Hours Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Mudical Examiner must be notified at Beleam HARFORD To Be Completed by Funeral Director 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 21017 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 1 Never Married ō 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic svent, Ite Ma. 20108. Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be heador 19b. Mailing Address (Street and Kegika FINCh 20a. Method of Disposition 3 Removal from State Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANJ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospitat or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death Year 5 ☐ Other (specify) 1 Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ces Be Completed 2 No 3 Probably 4 Unknown cate has b page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 Yes 2 No 1 Yes 2 0 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: this 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending within 24 hours after death, To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 🗍 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 33 MAY 1 7 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



<b>5</b> 2(	04		1 - For Unpend Item 2					•	iene () () 5	16596			
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Death	2. Date of Deat		3. Time of Death			
	Physici /Medi		ANDREW	MOREY	REVELS			May Month	11 <sup>Pay</sup> 2005	6:20 P M			
	Examir		4a. Facility Name (If not institution, give s 2916 Georgetown R			4b. City, Town, o Baltir	r Location of Death		4c. County of Dea	ath N/A			
	Funeral Director		210 00 1014 "	7. Age (I	n yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 09/13/	1959 MA	rthplace (State or Foreign country) ARYLAND			
5	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County N / A	11	Dc. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
	h with the 3e or 28e st be noti	al Direc	10e. Street and Number 2916 GEORGETOW	N ROAD		10f. Zip Code 212	30	10	Og. Citizen of What Country?				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumetic event. The Mardical Examinar must be neitlied at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2X No	Ispanic Origin? (Spe an, Mexican, Puerto Specify:	acify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:				
	ithin 72 ho ne. nen "natur Medical	Completed	15. Decedent's Educification (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	DO NOT use retired	during most of worki 1)	ing	16b. Kind of Business	s/Industry			
2	filed w Hygier Sther tl		17. Father's Name (First, Middle, Last)	STEVEDO	RE 18. Mother's Name		LONGSHOR	REMAN					
aŭ	ld be hental ked o ic eve	o Be	JESSE B. REVELS JR.				LUCY		EWIS	unoy			
ary	2 should be and Mental is marked i	-	19a. Informant's Name/Relationship (Type	оө, Print)	19b. Mailir	ng Address (Street	and Number or Rura		City or Town, State,	Zip Code)			
	1 and 2 Health em 27 i		ANTHONY L. REVE			CHADWI	CK CT SI		ROVE, PA				
200	Pages 1 nent of H ent: If ite		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ R		20b. Place of Dispo cemetery, cren HOLLY H	sition (Name of natory or other plac TT.T CTM	(e)		20c. Location - City o				
Baltimore,	permit. Page Department of Importent: If any injury of once.		1 Burial 2 Cremation 3 Removal from State HOLLY HILL CEM. 5/16/05 MIDDLE  21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FI  22. Name and Address of Facility CVACH/ROSEDALE FI  23. Name and Address of Facility CVACH/ROSEDALE FI  24. Donation 5 Other (Specify) CVACH/ROSEDALE FI  25. Name and Address of Facility CVACH/ROSEDALE FI  26. Name and Address of Facility CVACH/ROSEDALE FI  27. Name and Address of Facility CVACH/ROSEDALE FI  28. Name and Address of Facility CVACH/ROSEDALE FI  29. Name and Address of Facility CVACH/ROSEDALE FI  21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FI  21. Signature of Funeral Service Licensee 23. Name and Address of Facility CVACH/ROSEDALE FI  21. Signature of Funeral Service Licensee 24. Name and Address of Facility CVACH/ROSEDALE FI  22. Name and Address of Facility CVACH/ROSEDALE FI  23. Name and Address of Facility CVACH/ROSEDALE FI  24. Name and Address of Facility CVACH/ROSEDALE FI  25. Name and Address of Facility CVACH/ROSEDALE FI  26. Name and Address of Facility CVACH/ROSEDALE FI  27. Name and Address of Facility CVACH/ROSEDALE FI  28. Name and Address of Facility CVACH/ROSEDALE FI  29. Name and Address of Facility CVACH/ROSEDALE FI  20. Name and Address of Facility CVACH/ROSEDALE FI  20. Name and Address of Facility CVACH/ROSEDALE FI  21. Signature Of Facility CVACH/ROSEDALE FI  21. Signature Of Facility CVACH/ROSEDALE FI  21. Signature Of Facility CVACH/ROSEDALE FI  21. Signature Of Facility CVACH/ROSEDALE FI  22. Name and Address Of Facility CVACH/ROSEDALE FI  23. Name and Address Of Facility CVACH/ROSEDALE FI  24. Signature Of Facility CVACH/ROSEDALE FI  25. Signature Of Facility CVACH/ROSEDALE FI  26. Signature Of Facility CVACH/ROSEDALE FI  26. Signature Of Facility CVACH/ROSEDALE FI  26. Signature Of Facility CVACH/ROSEDALE FI  26. Signature Of Facility CVACH/ROSEDALE FI  26. Signature Of Facility CVACH/ROSEDALE FI  26. Signature Of Facility CVACH/ROSEDALE FI  27. Signature Of F										
	10100	-	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate										
	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Methadone  Due to (or as a co	Intoxica		-			Interval Between Onset and Death			
	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury	Due to (or as a co	onsequence of):								
,09/	ite be executed lysician and he burial-transit	cal Examiner	that initiated events resulting in death) Last  Due to (or as a consequence of):										
P.O. Box 68	death certifica e attending ph id tor use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	oregnancy Fetal death 3 e of death 5			23d. Date of de Month	olivery Day Year					
S,	res that the de igned by the a be detached t	by Pł	Part II. Dther significant conditions con			nderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	to the cause of death?			
ord	w require been signal	ted	Hypertensive Cardi	ovascular	Disease			1 🗆 Ye	s 2□No 3□P	robably 4 Unknown			
of Vital Hecords,	The far ate has page 2	Completed						24a. Was an autopsy perform	/ prior to	utopsy findings available completion of cause of			
7	Physician: r this certifica ral director, I	o Be	25. Was case referred to medical examiner?  1 X Yes 2 No	ospital:	2 ER/Outpatien	• 3 DOA Othe	26. Place of Death		nce <b>X</b> □Other <i>(Sp</i> e				
on of \	nding Physath. r: After this e funeral dir	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury Found th, Day Ye	28b Time of	28c. Injun	at 2		w injury occurred	unk at scene			
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5)  Found at	- At home, farm, stre Specify) residence	eet, factory, office	B	28f. Location (Str City or Town, Baltimore	eet and Number of G State) 2916 G e, Marylan	eorgetown Rd			
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Phys 2 ☒ Medical Exemin	ician: To the best of mer: On the basis of exand manner stated	amination and/or inv	occurred at the time time of the stigation, in my of	ne, date and place, a pinion, death occurre	and due to the ca ad at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)			
	To t To t	Σ	29b. Signature and title of certifier	n i D			OOME			signed (Month, Day, Year) 12, 2005			
				mid			Street	Baltimor	e, Maryla	nd 21201			
	Sta Registr		31. Date filed (Month, Day, Year)	37 Registrar's	Signature	with							

			1 - For State Registrar	State o	of Maryla		artment of H				iene	)5	1659	1
			Decedent's Name (First, Middi	le, Last)						. Date of Deat	h		3. Time of De	ath
	Physici /Medio		Barbara Jean Re	uwer					N	Month Iay 10,	Day 2005	Year	4:15 p	М
	Examir		4a. Facility Name (If not institution		ımber)		4b. City, Town, or	Location of		10,	4c. County	of Death	4:15 p	
			North Arundel H	lospital			Glen Bu	ırnie			Anne	Arun	de1	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under		. Date of Birth			place (State or Fo	oreign
	Director		212-05-2611	1 ☐ M 2 🖾 F	64	Yrs.	Months Days	Hours	Min,	(Month, Day,		Mary	land	
	p.		Usual Residence of Decedent							-A·,	17 10			
	aryla	_	10a. State 10b. County		10c. C	city, Town or Lo	ecation					1	Od. Inside City L	
	Ba-f	cto	MD Baltim	ore	Re	isterst	own						1 ☐ Yes 2	⊠No
	or 2	Director	10e. Street and Number				10f. Zip Code			10	og. Citizen of	What Coul	itry?	
	ath w 23e		305 Delight Me	adows Rd.			21136				USA	A		
	tems	Funeral	11. Marital Status	12. Was Dec Armed Fe	edent Ever in torces?	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin, Mexican	gin? (Specif	fy Yes or No- can, etc.)		e - Americk, White,	can Indian,	
36	s afte	by F	1 Never Married 2 Mar	If Yes, Gi	ve		1 ☐ Yes 2√☐ No		white		1	whi		
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28a-f show he Medical Examinar nust be notified at	d b	3 Widowed 4 Divorced		ates:									
5	"nei	Completed	(Specify only highe	it's Education st grade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired.	durina most	t of working		16b. Kind of B	usiness/In	dustry	
12	withi ene. then	щ	Elementary/Secondary (0-12)	College (	1-4or 5+)		DO NOT USB TBUTBU,	,			3.7			
	fifed Hygi ther int.		12 17. Father's Name (First, Middle,	Last)		None		18 Mothe	r's Name (	First, Middle, N	None	101		
au	of o	Ве	Charles Reuwer									10)		
2	d Me mark mati	Ţ	19a. Informant's Name/Relations	hin (Tune Print)		10h Mailie	ng Address (Street a			Schlos		O		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23e or 28a-1 show eny injury or other treumatic event. The Medical Examinar is ust be millised at once.		Susan B. Gamb		n		elight Me							1126
	1 an Heal em 2		20a. Method of Disposition				sition (Name of	adows	Date:		Oc. Location -			1130
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		_	JUIN X	JOIMA	rigor		620 Wilke					Tand	21229	
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k	5	_	Sequentially list conditions,	Hom	V	inuria	-1-464	M	MI	ndal	164	(	mgenita	1
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	and I-tran	кап	that initiated events resulting in death) Last	c. Punto	10 Jun		Tracto	114					Chile Jule	4
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87	cate o	dical		d										
9 ×	The law requires that the death certific let has been signed by the attending page 2 should be detached for use as	Physiclan/Me	IF FEMALE:	220 11.000 000										
Вох	attendation us	lan	23b. Was decedent pregnant in the past 12 morths?		irth 2 Fet	aldeath 3 [	Ectopic pregnancy				23d. Dat	e of delive	ry Day Year	
o.	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟ Pregr 9□ Unkn	nant at time of o	death 5 _	Other (specify)					101	Day Foar	
٣.	that the de led by the a detached f		Part II. Other significant condition	one contributing to d	anth but not ro	oultime in the		- i- D- 41		OD Did sob		::		
ŝ	signed	by	Tan in other organization	one contributing to d	Balli Dal Hol I B	sulling in the ui	idenying cause give	ının Parti.			_		e cause of death	
O C	v requii been s should	tec								1 🗆 Yes	2 12 110	3 Prob	ably 4 □Unkn	own
Records,	e law has b	Completed								24a. Was an autopsy	'   p	rior to con	osy findings avail	lable e of
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Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					26. Place	of Death (C	Check only one	)			
of	Physi this c	2	1 ☐ Yes 2 ☐ No			A/Outpatien	t 3□ DOA Othe	r. 4□ Nur	rsing Home	5 🗌 Resider	ice 6 Othe	er (Specify	)	
u u	ding P	on:	27. Manner of Death 1 ☐ Matural 5 ☐ Pendin	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	at	280	I. Describe hov	v injury occurr	ed		
Sio	Attending or death. ector: After by the fune	catl	2 Accident investig	gation			M 1 □ Y	es 2□N	No					
Division	l or Attendate death Director:	Certification;	3 Suicide 6 Could at determ	inad 286. Place	of Injury - At h	iome, farm, stre	et, factory, office		28f.	Location (Stre City or Town,		er or Rura	Route Number,	
	rs al													17
	ne Hospitel or Al 124 hours after of 125 hours after of 125 hours after of 136 hours after of by	edical	(Check only 2 Medical	g Physician: To the Exeminer: On the ba	best of my knoasis of examina	owledge, death	occurred at the time	e, date and	d place, and	due to the cau	use(s) and ma	nner as sta	ited.	
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Med		and man	ner stated.		- 7							
	or with	-	29b. Signature and little of certifier	- D1	1	in	29c. License		u/	29	d. Date signed	(Month, L	ay, Year)	
1	111		waty	0	all	"リ		-009	У		05/1	1/61		
1-	76		30. Name and address of person	who completed caus	e of death (Iter	m 23a) (Type, I	Print)	OX	A	0 /	111	/	1.1	0/1
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	riegisti	20	111111111111111111111111111111111111111	CUUD Me	8.00 . 1	631	AP 4							

		1- State of Maryland 1- State of Maryland Per DVR, 05/1	*Certificate of Death	Reg. 2. Date of Death	No.	3. Time of Death	
Physic /Med		Quan LANDEN REEVE :	111	Month	Day Year	4:15 4 M	
F.,,,,,,,		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deal		
26		MAROUNA Heritage	JAKRETTSUILL		PHAREIN	D	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs.  Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Co	hplace (State or Foreign ountry)	
> Director		202-05-0377   SAM 2   86		12/13/191	8 Mar	yland	
Maryland -f ehow			own or Location			10d. Inside City Limits	
6 Ma	ctol	MD Baltimore M	onkton			1 □ Yes 2X No	
death with the	Funeral Director	1916 Monkton Road	10f. Zip Code <b>21111</b>	10g.	10g. Citizen of What Country?		
y Seath	era	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	nican Indian,	
15-0036 In 72 hours after death with the Marylan natural; or items 23a or 28a-f show sedical Examinat mention and continued at	þ	1 Never Married 2 Married 1 Myes 2 No WWI. 3 Widowed 4 Divorced Year or Dates:		Rican, etc.)	Black, White, etc.  Specify: White		
1215-0036 within 72 hours after ene. natural, or lite than "natural, or lite the Medical Examina	Completed	(Specify only highest grade completed)	Give kind of work done during most of work life. DO NOT use retired)	ing 16b	. Kind of Business	Industry	
d 212- d 212- filled within Hygiene. Sther than	E O	Elementary/Secondary (0-12) College (1-4or 5+)	POST MASTER		POSTAL S	SERVICE	
Maryland 2 d 2 should be filed the and Mental Hygin 77 is markad other traumatic event, II	To Be C	17. Father's Name (First, Middle, Last)  PAUL FRANCIS REEVE	18. Mother's Name  ANITA	e (First, Middle, Maid			
		19a. Informant's Name/Relationship (Type, Print)  MARTHA REEVE - daughter	9b. Mailing Address (Street and Number or Rura 1916 MONKTON ROAD M	E		Zip Code)	
ore, M ss tand 2 of Health litem 27 i		20a. Method of Disposition 20b. Place			. Location - City or	Town, State	
Page Page ment of ury or		Liburar 2 Cremation 3 Premoval from State		4/2005 M	onkton, 1	<b>1</b> D	
Baltimore, permit. Pages 1 at Department of Hea Important: If tem any injury or other any injury or other		21. Signature of Funeral Service Licensee  R. Adrian Monaco per DVR	22. Name and Address of Facility He 16924 York Road, Mo	nry W. Je		Sons,Co.	
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Description of the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	o not enter the mode of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death	
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68. tifficate g phy as the							
Records, P.O. Box 68 The law requires that the death certifical tent has been signed by the attending phy bage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deadle Pregnant at time of death	23d. Date of del Month	ivery Day Year			
S, P. es that I		Part II. Dther significant conditions contributing to death but not resulting		23e. Did tobacc	co use contribute to	the cause of death?	
cords, v requires been sign should be	ed b	Atze heines Diasal, the pother	clear	1 🗆 Yes	2 No 3 Pr	obabiy 4 Unknown	
Division of Vital Records, for Attending Physician: The law requires the after death. Diractor: After this certificate has been signed in by the funeral director, page 2 should be designed.	Completed by			24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of	
ysician: ysician: is certifica	BeC	25. Was case referred to medical	26. Place of Death		10 105		
of Vita Physician: this certific	2	/ _		me 5 Residence		cify)	
sion of anding Physeath.  or: After this he funeral di		1X Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	D. Time of 28c. Injury at Work?  M 1 \[ Yes 2 \] No	28d. Describe how in	njury occurred		
IVIS rAtt er de racte	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury · At home building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Ru tate)	ral Route Number,	
D tafo	0	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowled 2 Medicel Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
Dispetation of the Hospitation of the Hours affine Funeral Dispetation of Hetely filled in	edic			204	Date signed (Monti	Day Vocal	
To the Hospital o within 24 hours aft To the Funeral Di completely filled in	Medical	29b. Signature and title of certifier	29c. License number		1 .	i, Day, Tear)	
DIVISION Of To the Hospital or Attending Phys within 24 hours after death. To the Funeral Diractor: After this completely filled in by the funeral di	Medic	29b. Signature and title of certifier  Which Kliffy mo	29c. License number  23/295		5/5/05	, Day, Tear)	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 15:00 Ma 12 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospit BALTIMORE
If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2**⊠**F 78-05-3669 Yrs. Director VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or itams 23a or 28a-f show the Modical Exempter must be notified at 1 Yes 2 No BALTIMORE Directo ARKVILLE MARYLAND 10e. Street and Number 10g. Citizen of What Country? USA 1FORD COUR! Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 ☐ Widowed 4 🔀 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) ROCUREMEN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) MR. JAMES 150N BALLIMORE, MARYLAND 21234 Date 20a. Method of Disposition 20c. Lostion - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State `4 Donation 5 Dother (Specify) OF HEAVEN CEMETERY S SILVER SPRING, MARYLAND permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARZULLO FUNERAL LAPEL, P.A. Michael 6009 HARFORD KOAD BALTIMORE MARYLAND 21214 23a. Part1. Enter the disease, or component on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? res 25(No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No 1 Inpatient ů 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of Medical Certification: 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No nours after death nerat Director: / filled in by the fi investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

Ledy S

D0016221

D. Marsico

29d. Date signed (Month, Day, Year)

May

2005

within 24 hours a To the Funerat D Registrar

West Belvedere Avenue 2401 31. Date filed (Month, Day, Year) 32. Registrar's Signature ORIGINAL

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

29b. Signature and title of certifie

VOID
CERTIFICATE 88
2005-16600

SEE

CERTIFICATE #

2005-43884

			For State		aryland / De	partment of I	Health and Mo		9	16601
			* Registrar	- 41	<i>U</i>	ertificate of		Reg. f	40.	10001
	Physici	ian	1. Decedent's Name (First, Middle, La:  ROSIE K.						Day Year	3. Time of Death
	/Media	cal		SMITH					3 2005	1100 BW
	Examir	ner	4a. Facility Name (If not institution, give			0 11	or Location of Death		4c. County of Death N/A	1
4			5. Social Security Number 6. S	0	Marin hat hirther		If Under 24 Hrs.	0.5000 06.500		-1 (0) (
- 2	Funeral Director			_M 25€F 7. Age	e (In yrs. last birthdi 9 2 Yrs	Months Days		8. Date of Birth (Month, Day, Yea	ar) 9. Birth	nplace (State or Foreign untry)
Smith			Usual Residence of Decedent		<u> </u>			08/30/1	912 MA	RYLAND
0 /	/land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
2	Many Ted	ţ	MD N/A		BALT	TIMORE C	ΓͲΥ			1 XYes 2 □ No
2150	r 288	irec	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Cou	untry?
0	rs after death with the Marylar ", or Items 23a or 28a-f show	D E	3717 HOWARD P.	ARK AVENU	JE	2120	7		USA	
~	deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?			Hispanic Origin? (Spec an, Mexican, Puerto P	ify Yes or No-	14. Race - Amer	
, 9	after or Ite	J.	1 Never Married 2 Married	1 ☐ Yes 2 XN If Yes, Give	lo	1 ☐ Yes 2X No		ilcari, etc.)	Black, White	
S-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Mcolinal Examination at the motified at	Completed by Funeral Director	3 ☐ Widowed 4 X Divorced	Year or Dates:					Specify: BI	LACK
2 <u>r</u>	72 h	ete	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. De	cedent's Usual Occupive kind of work done	pation during most of workin d)	16b.	Kind of Business/li	•
2 2	within ne. han	mp	Elementary/Secondary (0-12)	College (1-4or 5	+)	e. DO NOT use retire	ad)		HUTZLER' BAKERY	S
721	77 75 5	ပိ	12TH  17. Father's Name (First, Middle, Last)		SAI	ES ASSOC		(First, Middle, Maid		
al é	ed las	Be		HOLS SR.			ANNIE		sii Suinailie)	
V-row	d 2 should th and Men 7 Is marke traumatic	70	19a. Informant's Name/Relationship (		10b M	ailing Address (Stroot	t and Number or Rural	KEENE	v or Tour State 7	
Ma	d 2 sho th and 17 Is ma traums		MARIAN E. CARTI				PARK AV			
+ 0	s 1 and 2 f Health item 27 l		20a. Method of Disposition		20b. Place of Dis	sposition (Name of	Da		Location - City or T	
ather			1X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specific	Removal from State		rematory or other pla MN CEMET	ERY 5/20		,	
上重	artme artme artan injur		21. Signature of the ral Service Licer		NOODEA.				TLIMORE	CO., MD
Ba	pernit. Page Decartment of Important: If any injury or		1 // WY	111.11	nou	4600 T.TR	SEPTY HET	CRAG YILE FPP LONE	RAL HOM	IE 21207 IMORE, MD
a -			23a, Pan E ne disease, or com	olications that caused	the death to not	enter the mode of dvi	ng such as cardiac or	respiratory arrest	BAL1	Approximate MD
	September 1		23a. Part F ne disease, or com shoo, or yeart failure. List only	one cause on each lin	ie.	. (1960)	0 \	Toophia.o., allow,		Interval Between Onset and Death
	Priysician /Medical		fmmediate vause (Final disease condition resulting in death)		gestre	- heart	tailure			20 years
	Examiner				corsequence of):	11				Sections
		e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of):	deid o	102508			Longitus
12	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury		1	·				
/	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):					
760,	0 5 0	cai	(	d. —						
	leath certificat attending phy i for use as th									
Box 68	n cert	<u>N</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of deliv	very
Ď.	that the death ed by the atte detached for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 4 ☐ Pregnant at 1		3 □Ectopic pregnanc 5 □ Other (s <i>pecify</i> ) _	y 		Month	Day Year
P.O.	t the by th tache	hys	9 Unknown	9□ Unknown						
, T	s tha	Completed by Physician/Med	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the	e underlying cause giv	ven in Part I.	23e. Did tobacco	o use contribute to t	the cause of death?
Ë	w requires been signi should be	ed	bushoused					1 🗌 Yes	2 No 3 Pro	babfy 4 Unknown
S	aw re is be	plet	record inso	Hierence				24a. Was an	24b. Were aut	opsy findings available
æ	The lav	E O		1				autopsy performed?	death?	ompletion of cause of
ta	rtifica	Be C	25. Was case referred to medical				26. Pface of Death		10 12 103	20110
>	ysician: is certific director,	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier	nt 2 ER/Outpat	tient 3 DOA Oth	200	e 5 Residence	6 ☐Other (Speci	ify)
0	ding Ph h. After th funeral	ü	27. May er of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	y 28b. Time		ry at 28	8d. Describe how in	ury occurred	
<u>.</u>	andir ath. or: Af	atic	2 Accident investigation	1			Yes 2□No			
Division of Vital Records,	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm, . (Specify)	street, factory, office	28	Bf. Location (Street a City or Town, Sta	and Number or Rur	al Route Number,
	ital o irs aff ral Di	Cer		l,			- W			
	Hosp 24 bou Fune tely fil	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on the basis of	examination and/or	eath occurred at the till investigation, in my o	me, date and place, ar opinion, death occurred	nd due to the cause( d at the time, date a	s) and manner as s nd place, and due t	stated. to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Med	29b. Signature and title of certifier	and manner stat	ted.	29c. Licens	se number	29d. D	Date signed (Month,	Day, Year)
	⊢ ≮ ⊢ ŏ		DEO IV	111	15	RE	5000	2	12	2005
	1		30. Name and address of person who	completed cause of de	eath (Item 23a) (Tvo	pe, Print)	-3 000		= Y 15/	2003
	-		Edward Rad	der mt	Since	Hospit	al of B	alt, nore	) Negan	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	and a				
	Registr	ar	MAY 1 7 3	2005	Marker Butter	<b>建筑型的</b>				

	/Media	al	Francis Joseph	Schwarzman	Sr.				may	10	1 2005	3:52P	
	Examir	er	4a. Facility Name (If not institution, g	4.4	1		S	, or Location of De	eath o		c. County of Death		
		45	tranklin Squar			nter		SEDQE ar If Under 24 F	dre a s		Daltim	ore	
ŀ	Funeral Director		212 07 2376	.Sex 7.Age	88	ast birthday) Yrs.	If Under 1 Yea Months Day		lin. 8. Date of Bi (Month, D June 8,	irth a <i>y, Yea</i> .191	r) 9. Birth Con Mar	nplace (State or Foreig untry) yland	
	pur &		Usual Residence of Decedent  10a, State 10b, County		10c City	, Town or Loc	ation					104 1-14-04-11-1	
	Aaryla I sho	20	Maryland		roc. Ony		imore					10d. Inside City Limit 1XYes 2 □ N	
nd 21215-0036	28a-1	ect	10e. Street and Number				10f. Zip Code			10a C	itizen of What Co		
	th with 23s or	Funeral Directo	5733 Moravia Rd.				2120			rog. o	USA	and y :	
	ems	ıner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	S. 13. W	as Decedent o	f Hispanic Origin?	(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Amer Black, White		
	within 72 hours after death with the Maryland ane. than "natural; or Items 23s or 28s-1 show is Medical Evarunar must be notilled at	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced		lo		□Yes 212XN		,		Specify: Wh		
	n 72 ho "natur edical	Completed	15. Decedent's (Specify only highest			(Give k	ent's Usual Occ ind of work dor O NOT use reti	<b>ie d</b> urina most of i	working	16b.	Kind of Business/I	ndustry	
	filed within Hygiene. other than "	Somp	Elementary/Secondary (0-12)	College (1-4or 5-	+)		er For	•		Car	dboard B	ox Mfg.	
	be file Ital Hy Id oth event	Be (	17. Father's Name (First, Middle, La	st)					Name (First, Middle		n Sumame)		
<u>S</u>	Mer Mer arke	ပ	John Schwarzman					Elizab	eth Eyrin	ıg			
Baltimore, Maryland	2 sho and ie m		19a. Informant's Name/Relationship	, ,, ,					Rural Route Numb			*	
	Ð € ► ♣		Francis J. Schwa	rzman Jr. (					ltimore,	Mar	yland 212	221	
	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Pla	ace of Dispos metery, crem	ition (Name of atory or other p	lace)	Date		Location - City or 1	own, State , Maryland	
	permit. Pag Department Important: any injury o		* 4 □ Donation 5 □ Other (Spe 21. Signature of) Funeral Service Lig		Dur							, Marytanu	
g	perm Depa Impo any i		21. Signature profundial Service Lie	Susa K	K	Ĕr	uzdzin	ski Fune:	ral Home	P.A.	- 252		
			23a. Par 1. Enter the disease, or co	IN MOCUSA	the death	12	m / OTa	Eastern	Avenue E	sse	x, $Md$ . $2$		
			erck, or heart failure. List on	ly one cause on each line	θ.		1.	ying, such as card		arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ACUTE Due to (or as a	My	100a1	digil	Infac	ction				
	Examiner		1	Due to (or as a	consequ	ence of):							
		-	Sequentially list conditions	b. COTONO	COD POUR	1+r+e	ry D	iscase					
	ted	Examiner	Sequentially list runditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	n: hal	00 /	1 1000	Paida	il i	A = 1   = = =				
-	xecu and	xar	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c. Diabetes Hyperlipidemiq Hypertension  Due to (or as a confequence of):						CA.				
3	certificate be executed iding physician and use as the burial-transit				•								
09/89	ficate physis the	edic		0.						-			
XOG		N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date of deliv	(AD)	
	death a atte	hysician/Medical	in the past 12 months?	1□Live birth 2 4□Pregnant at t			ctopic pregnar Other (specify)	ncy			Month	Day Year	
j.	at the death by the atte	hysi	9 Unknown	9□ Unknown									
ī	s that ned t	by P	Part II. Other significant conditions	contributing to death bu	it not resul	ting in the und	ferlying cause (	given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
ecords,	w requires that the death been signed by the atter should be detached for u								_ 1 🗆	Yes 2	2D No 3□Pro	bably 4 Unknown	
ပ္တ	> 10 (5	Completed							24a. Was		24b. Were aut	opsy findings available	
r	o - o	mo								ormed?	death?	ompletion of cause of 2 No	
VItal	ician: Th certificate rector, pag	a	25. Was case referred to medical					26. Place of D	1 ☐ Yes Death (Check only	2[N	0 10165	2 140	
	Physician: r this certific ral director,	o B	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	nt 2 1 E	R/Outpatient	3□ DOA	thor	Home 5 ☐ Res		6 ☐ Other (Speci	(fv)	
101	g Physier this	ıı: T	27. Manner of Death	28a. Date of Injury (Month, Day		28b. Time of Injury	28c. Inj		28d. Describe			.,,,	
VISION	Attending In death.	atlo	1 Natural 5 Pending 2 Accident investigat		7007)	injury		☐Yes 2☐No					
<u>  S</u>		ertification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At hon	ne, farm, stree	et, factory, offic	9	28f. Location ( City or To		and Number or Rur	al Route Number,	
5	rs aft al Di	O											
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying 2 Medicel Ex	Physicien: To the best of eminer: On the basis of and manner state	examination	riedge, death on and/or inve	occurred at the estigation, in my	time, date and pla opinion, death oc	ice, and due to the ccurred at the time,	cause(s date ar	s) and manner as and place, and due t	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/ / -			29c. Lice	nse number		29d. Da	ate signed (Month,	Day, Year)	
	/1		Hunk	ule an)	)		13:	53345			5/14/6	1	
	h		30. Name and address of person wh	o completed cause of de	ath (Item 2	23a) (Type. P	rint)				, , -	7	
	10		DCT //-		nm E			no Do	1.11		CO 144.0 0	1277	

1. Decedent's Name (First, Middle, Last)

Francis Joseph Schwarzman Sr.

**Physician** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Year

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1XYes 2 □ No

2. Date of Death

Month

DHMH 17 Rev 1/2001

State Registrar

Dr. Thomas

Krisanda 9000 Franklin Square Drive Baltimore Mu 21337

			1 - For State Registrar	State of Maryland / D	epartment of Health and Certificate of Death		giene 005	16603					
	Physicia		1. Decedent's Name (First, Middle, Las Josef Sunzenaue	•		2. Date of Dea	Pay 2005	3. Time of Death 11:15 рм					
	/Medic Examin		4a. Facility Name (If not institution, give Casey House Mon	street and number) tgomery Hospice	4b. City, Town, or Location of De- Rockville	ath	4c. County of Death Montgomer	У					
	Funeral Director			C C. C.	hday) If Under 1 Year If Under 24 H Months Days Hours Mi		9. Birthpla Country	ce (State or Foreign Y) Austria					
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location	· · · · · · · · · · · · · · · · · · ·	100	I. Inside City Limits					
	he Mar 8a-f sl	Director	MD Montgo	mery Bethe			10. 6%	1√2Yes 2 No					
	h with t	al Dir	10e. Street and Number 4400 West Virgin	nia Ave	10f. Zip Code 20814		10g. Citizen of What Country Austria	y r					
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Items 23a or 28a-f show amportent: If Item 27 is marked other than "natural; or Items 20a or 28a-f show apprintury or other treumette event, Ita Madical Exaction must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3∰Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 [] Yes 2 2 5] No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 ☐ Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Americar Black, White, etc Specify: Whi	c.					
21215-0036	n 72 ho "natu	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	Decedent's Usual Occupation (Give kind of work done during most of w life, DO NOT use retired)	rorking	16b. Kind of Business/Indu	stry					
212	ed withi giene. er than , tre M	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	Cabinet Maker		Wood Worki	ng					
Maryland	uld be file Aental Hy rked oth	To Be (	17. Father's Name (First, Middle, Last)  Josef Sunzenaue:			ame (First, Middle, efa Sunzei							
Mary	12 sho h and h 7 Is ma treume		19a. Informant's Name/Relationship (7 Ingrid Sunzenaue		Mailing Address (Street and Number or 4606 Woodfield Rd.			ode)					
re, l	os 1 and of Healt item 2 rother		20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or Town	n, State					
Baltimore,	t. Page tment c tent: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Chesar	peake Crematory 05	-14-2005	Beltsville,	MD					
Ba	Depar Depar Impor any ir		21. Signature of Funeral Service Licen	,,,,,,,,,,	22. Name and Address of Facility Rapp Funeral & (								
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death										
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a									
Р	Examiner		Sequentially list conditions, if any, leading to immediate	b									
7	uted d ansit	Examiner	if any, leading to immediate cause. Enter Under vin Cause (Ulsease or injury that initiated events	Due to (or as a consequence of	π):								
30,	icate be executed physician and s the burial-transit	I Exa	resulting in death) Last	Due to (or as a consequence of	of):								
68760,		edlcal		_ d.									
P.O. Box	or Attending Physicien: The law requires that the death certif the death certif death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Vas decedent pregnant nthe past 12 months?  Yes 2 No   No   No   No   No   No   No   No									
	ires tha signed I d be det	by	Part II. Other significant conditions of Coronary Artery		the underlying cause given in Part I.		obacco use contribute to the						
Records,	w requir been si should	leted	Colonaly Aftery	Disease		24a. Was		y findings available					
Re	The lay ate has page 2	Completed				autop perfo	prior to comp rmed? death? 2√√No 1 ☐ Yes 2	eletion of cause of					
Vital	sicien: certific rector,	o Be (	25. Was case referred to medical examiner?	Hospital:	Lau	eath (Check only o							
of	ng Phys ter this neral di	<b>—</b>	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b. T	patient 30 DOA 40 Norsing		dence 6 Other (Specify) now injury occurred	nospice					
Division	ttendir death. :tor: Af	catic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2 No	28f Location (9	Street and Number or Rural F	Route Number					
Div	s after of A Direct of in by	Certification;	4 Homicide determined	building, etc. (Specify)	in, street, ractory, onice	City or Tox		ioute vumber,					
	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)	ysician: To the best of my knowledge niner: On the basis of examination and and manner stated.	, death occurred at the time, date and pla d/or investigation, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner as stat date and place, and due to th	ed. ne cause(s)					
)	To th withir To th comp	Ž	29b. Signature and title of pertition	N. W.	29c. License number  0 4 1 2 15	2	29d. Date signed ( <i>Month</i> , <i>Da</i>	ny, Year)					
	6		30. Name and address of person who			MD 20055	1-1-1						
	Sta	te_	Charles Harriso 31. Date filed (Month, Day, Year)	n 6001 Muncaster 32. Registrar's Signature	Mill Rd. Rockville	MD 20855							
		State Registrar  Charles Harrison 6001 Muncaster Mill Rd. Rockville Fib 2005  31. Date filed (Month, Day, Year)  AV 1 7 2005  32. Registrar's Signature											

DHMH 17 Rev 1/2001

ORIGINAL

		For State	State	of Marylan		artment of H			giene Reg. No. 005	16604
		Registrar     Decedent's Name (First, Middle)	e, Last)	2. Date of De	ath	3. Time of Death				
Physicia								Month	Day Yea	10:00 PM M
/Medica Examine		Ulrich Oscar So 4a. Facility Name (If not institution	nderegge: n, give street and n	r, III		4b. City, Town, or	Location of Death	May 13	2005 4c. County of D	
Examine	25	Haven Nursing H				R	altimore		Baltimo	re City
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th 9	Birthplace (State or Foreign Country)
Director		219-26-5263	M 2□F	71	Yrs.	Months Days	Hours Num.	08/08/		
P .		Usual Residence of Decedent		10a Cit	y, Town or Lo	antina.				10d. Inside City Limits
ith the Marylen or 28e-f ahow a cottilled at	2	10a. State 10b. County		100.01	ly, town of Lo	CallOII				1 Yes 2 □ No
98 -1 M	Director		more City	Bal	timore	10f, Zip Code			10g. Citizen of What	Country
Mith to	吉	10e. Street and Number				Tor. Zip Code			-	
s 23a	era!	3939 Penhurst A		cedent Ever in U	S 13 1	21215 Was Decedent of Hi	Isnanic Origin? (Sc	pecify Yes or No	United St	ates mencen Indian,
itam Itam	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Armed	Forces?	.5.	f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		/hite, etc.
irs et	by	3 □ Widowed 4 Divorced	If Voc (	Sive " evi£		1 ☐ Yes 2 No	Specify:		Specify:	nite
72 hours efter deeth w "natural", or Itams 23a	ted	15. Deceder	nt's Education	-1	16a. Dece	dent's Usual Occupa	ation	ina	16b. Kind of Busine	
Madi	pie	(Specify only highe Elementary/Secondary (0-12)	<del></del>	(1-4or 5+)	life.	DO NOT use retired	)		Meat Pack	ing Plant
d wit	Completed				Quali	ty Contro				<del></del>
be filed within 72 hours efter deeth with the Marylend lat Hygiene. Id other than "natural", or itams 23a or 28e-f ahow avent, the Madical Examinar must be notified at	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
2 should be filed within and Mental Hygiene. is marked other than aumatic avent, the Mental Hygiene.	၉	Ulrich Oscar Sc	nderegger	, II				ller		
and is m		19a. Informant's Name/Relations			19b. Mailir	ng Address (Street a	and Number or Rui	rai Route Numbe	er, City or Town, Stat	e, Zip Code)
permit. Peges 1 end 2 should be filled within 72 hours efter deeth with the Maryle Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28e-1 ahov any injury or other traumatic avent, the Madical Expraner must be notified a once.		Jeanette Burges	Sister	205 5		Ocean Ga		lisbury Date	, MD 2180 20c. Location - City	
Peges 1 Peges 1 Tent of H Int: if Ite		20a. Method of Disposition  1  Burial 2 Ocremation	3 Removal fro		cemetery, crei	natory or other place	e)	May 16	200. Education Only	or rown, oraco
permit. Pege Depertment of Important: if any injury or	-	`4 □Donation <sup>®</sup> 5 □Other (S	-	Che	sapeal	ce Cremato	ory	2005	Beltsville	, Maryland
Dermit Deper Impor		21. Signature of Funeral Service	Licensee	M0093	K( ^	?. Name and Addres remati <b>o</b> n a		l Altern	natives	
10344		23a. Part1. Enter the disease, o	r complications the	t gauged the deat	B Do not ont	717 Green	Pastures	Drive F	Baltimore,	Maryland Approximate
		shock, or heart failure. Lis	t only one cause or	n each line.						Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a. 43	PIRH	-5/01	1 0077	H			
/Medical Examiner		,	Due t	o (or as a conseq	quenca of):	1 arit	FAIL	LUR	E	
	ē	Sequentially list conditions if any, leading to immediate	b. Due t	o (or as a conseg		( )			· · · · · · · · · · · · · · · · · · ·	
nstt	Ē	cause. Enter Underlying Cause (Disease or injury	<b>~</b>	(till	ov.	ia.				4
cete be executed physicien end the burlal-transit	Examin	that initiated events resulting in death) Last	C	o (ecas a conseq	uence of):	1				
1 E E	dicai		d	Dr.	me	ntea	-			
tificet og phy es th			<u> </u>							
h cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Ectopic pregnancy			23d. Date of Month	delivery Day Year
deet deet ed for ed for	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of o		Other (specify)			Month	Day real
by the	h.	9 Unknown			•			oo. Dida		a to the serves of death?
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requir sen si	Completed		FILMON	100	m.			ļ <del>-</del>	7	
les b	nple	- Hy	28 (hy)	mac	rm	110	7	24a. Was		autopsy findings available to completion of cause of
The The Pege	Co	Bar	len ge	no 1	lex	of ta	cken	1□ Yes	2/ZN3 1□	
VIIC Ician Sertiffi ector	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea	-		
Phys this aldir	2	1 Yes 2 46	11	Inpatient 2 te of Injury	ER/Outpatier 28b. Time o	1 3 DOA	4 Alersing H		dence 6 Other (5	Specify)
After funer	ion	1/⊟Natural 5 ☐ Pendi	/14	onth, Day Year)	Injury	Worl	k? Yes 2 ∐No			
ttank deatl ctor: y the	ertification;	3 ☐ Suicide 6 ☐ Could		ce of Injury - At h	lome, farm, st	reet, factory, office				r Rural Route Number,
To the Hospital or Attending Physicien: within 24 hours efter death. To the Funeral Director: After this certificompletely filled in by the funeral director.	ert	4 Homicide	bu bu	ilding, etc. (Speci	fy)	•		City or To	wn, State)	
spita nours neral	aic	29a. Certifier 1 Certifyi	ng Physician: To	the best of my kno	owledge, deat	h occurred at the tin	ne, date and place	, and due to the	cause(s) and manne	r as stated.
na Ho na Fu	edicai	(Check only 2 Medica one)		basis of examina anner stated.	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and place, and	due to the cause(s)
To the Hospital or Attanding Physician: The lew requires that the death certifical within 24 hours effer death.  To the Funeral Director: Affer this certificate has been signed by the ettending physician by the funeral director, page 2 should be deteched for use as to explain the funeral director, page 2 should be deteched for use as the completely filled in by the funeral director.	¥	29b. Signature and title of certific	er J		1	29c, Licens	e number		29d. Date signed (M	fonth, Day, Year)
		· que	mila	n	2)	-0=	5/90)		>//3	101
		30. Name and address of person  AMBACKEN C	who completed ca	ause of death (Ite	m 23a) (Type,	Maryla Maryla	2. ov	y Ka	eto Me	121218
Sta Registr		31. Date filed (Month, Day, Year MAY 1	7 2005	. Pegistraf's Sign	ature	Maryla				

TOD:10:00 PM Ulrich Sonderegger DOD:5/13/05

State of Maryland / Department of Health and Mental Hygiene 16605 Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Year Ida Mary Seward May 12th, 2005 7:00 P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner 209 Regency Circle Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Morth, Day, Year)
an. 4, 1 223 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🖾 F Maryland 82 Director 218-14-8048 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes ⊋ ₩ No Funeral Director MDAnne Arundel Linthicum 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ USA 21090 209 Regency Circle or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married white Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Trave1 Travel Agent 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill tment of Health and Mental Hitant: If item 27 is marked other Thomas Vendemia Liboria UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Rumford Dr. #302 Catonsville, Maryland 21228 Mary Denise Pohlhaus-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of the Important: If its any injury or ot once. 15☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery May 18, 05 Baltimore City 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eagline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MyoCMO, AL INFORCTION

Due to (or as a consequence of): /Medical Examiner MERUSCUITURE CARDIOLOGIUM
oras a consequence of). PISTIASIS Sequentially list conditions, Examiner cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 should be 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed: 1 ☐ Yes 2 ☐ No 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) Medical Certification: To 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide he Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Spnatur and title o c 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SI8 CAMP MENOB RO. LINIT Ens MO State Registrar

)	00		4 17	artment of Health and Mertificate of Death	ental Hygie	7.000	16606	
I	Physic /Medi		Decedent's Name (First, Middle, Last)     KEONICA CRYSTAL SMITH		2. Date of Death Month MAY 10	Day Year	3. Time of Death	
	Examir		4a. Facility Name (If not institution, give street and number)  MALCOLM GROW HOSPITAL  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death CAMP SPRINGS If Under 1 Year   If Under 24 Hrs.	]	4c. County of Death PRINCE GEO	RGES	
	Funeral Director		577 98 0107 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye JULY 14,		lace (State or Foreign try) HINGTON, DO	
To the Hospital Director. After this cartificate has been signed by the attending by sician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		10a. State   10b. County   10c. City, Town or Location						
	the death certificat y the attending phy iched for use as the	ted by Physician/Medical Examine		□Ectopic pregnancy □ Other (specify) Inderlying cause given in Part I.	23e. Did tobacc	to use contribute to the	Day Year	
	The tar ate has page 2	e Completed	25. Was case referred to medical	Of Blood Date	24a. Was an autopsy performed 1 Yes 2	prior to com death?	esy findings available inpletion of cause of 2 No	
	ding Phy n. After this funeral o	Certification; To B	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year)  Injury	The state of the s		6 □Other (Specify,	5+	
	oitel or Att urs after d sral Direct		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet	29 Town. St.	1620-19	Bive.	
	the Hos thin 24 ho the Fund mpletely f	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, deat of the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	d at the time, date a	and place, and due to	the cause(s)	
	T 3 F 8		Note: 0 2001	29c. License number OCME	MA	Y 11, 200		
	9		30. Name and address of person who completed cause of death (Item 23a) (Type,	TII Penn Street Ba	altimore,	Maryland	21201	
	Sta Registr		MAY 1 7 2005	to the second				

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SENGER

CHARLES

		1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 005 16608	}
1	ician dical niner	1. Decedent's Name (First, Middle, Last)  Anna Mac Stafford  4b. City, Town, or Location of Death Month Day Year Year Year 4c. County of Death 4c. County of Death	
Funer Directo		Sinai Hospital of Bultimore  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Whonth Days Hours Min.  Whorth Day Year 35  9. Birthplace (State or Foreign Months)  Whoth Day Year 35  Pennsyl Vania	ign
the Maryland 28e-f show	rector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit MD NIA GALTIMORE 10f. Zip Code 10g. Citizen of What Country?	
ING 21213-UU36 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itams 23a or 28e-f show avant, the Medical Examinationals.	Funeral Director	3804 Violet Ave.  313/5  11. Marital Status 1 Never Married 2 Married 1 19 Never Married 2 Married 1 19 Never Married 2 Married 2 1 1 1 Never Married 2 1 1 1 1 Never Married 3 1 1 1 1 Never Married 3 1 1 1 1 Never Married 3 1 1 1 1 Never Married 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Z15-0036 ithin 72 hours af ie. "natural", or Medical Exam	Completed by	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Respondary (0-12) College (1-4or 5+)  1 Yes 2 No Specify: Specify: Specify: Black  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired)	-
aryland 212 should be filed with and Mental Hygiene s marked other that	To Be Con	17. Father's Name (First, Middle, Last)  Charles Peurifucy  Cook  18. Mother's Name (First, Middle, Maiden Sumame)  Mary E. Peurifucy	
and 2 salth a n 27 is		199. Mailing Address (Street and Number or Rural Route Number, Chr or Town, State, Zip Code)  199. Mailing Address (Street and Number or Rural Route Number, Chr or Town, State, Zip Code)  190. Mailing Address (Street and Number or Rural Route Number, Chr or Town, State, Zip Code)  190. Mailing Address (Street and Number or Rural Route Number, Chr or Town, State, Zip Code)  201. Mailing Address (Street and Number or Rural Route Number, Chr or Town, State, Zip Code)  202. Location - City or Town, State  203. Method of Disposition  204. Place of Disposition (Name of Date 205. Location - City or Town, State)	
t. Pag riment ritent: i	once.	21. Signature of uneral Service Lie 22. Name and Address of Facility  22. Name and Address of Facility  CANP MUPCH Flip 3 TO FREDIT CONFISS GRATE TO 3 3 3339	_
Physicia /Medica		23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or lear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Congestive Heart Failure  Due to (or as a consequence of):	
ate be executed hysician and hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
To the Hospitel or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1  Sectopic pregnancy 23d. Date of delivery Month Day Year	
w requires that been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown	n
cian: The law entificate has l	Be Completed	24a. Was an autopsy findings available autopsy performed? performed?   1   Yes   2   No   Yes   2    В	
or Attanding Physician: The lavaller death.  Director: After this certificate has in by the funeral director, page 2.	ုင	1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)  27. Manner of Death 1   Natural 5   Pending 2   Accident   Injury   Injur	
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	cal Certification;	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To tha Hospitel within 24 hours a To tha Funaral I completely filled	Medical	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
2	tate	Jones M. D. Doo54482 May 9, 2005  30. Namerald address of person who completed cause of death (Item 23a) (Type, Print)  Dr Patrick McLinkey 2401 W. Belvedene Ave Baltimore, MD 21215  31. Date filed (Month, Day, Year)  32. Registrar's Signature	
Regis	trar	MAY 1 7 2005	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Amend Item 4 Registrar	c&Unpend Item	23a 27 Cert	tment of Ho 28a-f na ficate of L	eaith and <b>er m</b> e G <i>leath</i>	Mental H 843 5-24	ygiene 1-05 ta: Reg. No.	<b>s</b> )5	16609
	Physici /Medi		1. Decedent's Name (First, Middle, Last)	Single tor	)			2. Date of I Month May	6, 2005	Year	3. Time of Death 8:37 A M
	Examir		4a. Facility Name (If not institution, give St. Agnes Hospital	street and Kun ber)		4b. City, Town, or Baltimor				unty of Death	
200	Funeral Director		512. 00. 000	7. Age (In yrs. las	- 1	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, L	Birth Day, Year) Z - 1973	Cou	place (State or Foreign intry)
0	aryland show	_	Usuel Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loca						10d. Inside City Limits
	the Ma	recto	10e. Street and Number	139	ltim	10f. Zip Code			10g Citizen	of What Cou	1 Tos 2 No
	ath with 23s or	la DI	317 S. Fulto	n tue.		212	223		Tog. Okizon	45	A
215-0036	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other than "naturel", or items 23a or 28a-1 show aumatic event, the Medical Examble in market per notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No- If Yes, Give Year or Dates:		as Decedent of His res, specify Cubar		Specify Yes or Note Rican, etc.)		Race - Ameri Black, White, ecify:	ican Indian, , etc.
15-0	natur	leted	15. Decedent's Edu (Specify only highest grade		16a. Decede	nt's Usual Occupa nd of work done do NOT use retired)	tion uring most of wo	<i>rki</i> n <i>g</i>	16b. Kind o	f Business/In	ndustry
212	filed within Hygiene. Ither than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		omema	4 -		Ho	me i	naker
Maryland	s 1 and 2 should be filed within 72 ho I Health and Mental Hygiene, item 27 is marked other than "natun other traumatic event, the Medical	To Be (	17 Father's Name (First, Middle, Last) Bobby Single				18. Mother's Na としい	e B	aum	gard	
	1 and 2 sh Health and Hem 27 is n		Huie Sinder	(mother	196. Mailing <b>317</b> S	Address (Street as	nd Number or R	ural Route Num		wn, State, Zip ZZZ	o Code)
Baltimore,	0 0 = =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	20b. Plac	e of Disposit etery, crema	ion (Name of tory or other place	)	Date	-	on - City or To	own, State
Itim	permit. Pag Department Important: I any Injury o		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signatuse of Funeral Service Lightness	wee	n Mo	Name and Address		7-05	121	1401	MKE St
Ba	permit. Departimonts any inj		Musil K	Eli	Ir	stegrita	Frenera	1 Sevu	زندی	B416	ESSLAW
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that sused the death. ne cause on each line.	Do not enter	the mode of dying	such as cardia	c or respiratory			Approximate Interval Between Onset and Death
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	Examiner	L	Sequentially list conditions,	, =							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	nce of):						
30,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequen	nce of):						
68760,	rificate be executed ng physician and as the burial-transit	edical									
.О. Вох	The law requires that the death certi tte has been signed by the attending tage 2 should be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3⊡E	ctopic pregnancy other (specify)				Date of delive Month	ery Day Year
<u>а</u>	es that the igned by be detact	y Ph	Part II. Other significant conditions con	tributing to death but not resulti	ng in the unde	erlying cause giver	n in Part I.	23e. Did	tobacco use co	ontribute to t	he cause of death?
Vital Records,	w require been sig should b							1	Yes 2 No	3 ☐ Prot	pably 4 □Unknown
Rec	The law cate has b page 2 sl	Completed			<del></del>			per	s an 24 opsy formed?	b. Were auto prior to co deatb?	ppsy findings available impletion of cause of
ital		Be Co	25. Was case referred to medical examiner?				26. Place of Dea	1 Yes ath (Check only	2□No one)	deatha 1 Yes	2 No
of V	Physicien: this certificaral director, p	2	1 TXYes 2 □ No		/Outpatient	and the second s	4 Universing F	lome 5 ☐ Res			
Division of	fing After fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		outid Outid	28c. Injury a Work? M 1 \( \text{Y} \)	at ? es 2.—∏Ro	28d. Describe	how injury occ	urred	unk
N. S.	al or Attend after death Director: A d in by the f	rtifica	3 ☐ Suicide 6 <b>X</b> Could not be determined	28e. Place of Injury - At home building, etc. (Specify)			-	28f. Location City or To	(Street and Nu	mber or Rure 06 Leh	Al Route Number,
٥	Hospital or 24 hours afte Funerel Dir tely filled in	Ce	29a. Certifier 1 Certifying Phys	House	dae death o	coursed at the time	date and place	Baltimo	ore, Md		
	To the Hospital within 24 hours a To the Funerel C completely filled in	edical	one)	er: On the basis of examination and manner stated.	and/or inves	tigation, in my opin	nion, death occu	irred at the time	, date and plac	e, and due to	o the cause(s)
	To To com	Σ	29b. Signature and title of certifier	Jr. 10	1.44	29c. License			29d. Date sign		
		İ	30. Name and address of person who co.	mpleted cause of death (Item 2:	Ba) (Type, Pri				raten	7, 200	
			MANANA N 31. Date filed (Month, Day, Year)	. KORECC 32. Registrar's Signature		111 Penr	Street	Balti	more, M	1aryla	nd 21201
	Sta Registr	4	MAY 1 7	2005	10	had.					
DHI	MH 17 Rev 1/20	001	mai [	and Jacobs	15		<del>-</del>				
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death w 8,2005 Year **Physician** 12:01 P<sup>M</sup> Leonard Scriber Мау /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) North Carolina 8. Date of Birth (Month, Day, Y June 22, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2 ☐ F 51 577-74-1320 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show er than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 No Maryland Prince Georges Clinton Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 7104 Redwood Branch Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours atter anent of Health and Mental Hygiene. and tell flem 27 is marked other than "natural", or fle any or othar traumatic event, the Madical Examina ury or othar traumatic event, the Madical Examina 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 🗆 Yes Specify: by es. Give 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNK MK IMI 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph A. Scriber Hattie B. McNeil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7104 Redwood Branch Ct., Clinton, MD 20735 Linda J. Scriber - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Nousial 2 □ Cremation 3 □ Removal from State permit, Page Department of Important: If any injury or Harmony Memorial Park | May 14,2005 Landover, MD 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service License 2. a. Part 1. Entry he sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. 3831 Georgia Ave., NW. Washington, DC 20011 Approximate Immediate Cause (Final my ocarded Inferction **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 8 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed pertension been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 Tyes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ZMatural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the I Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number JODRIE D40324 MAY 9, 2005 04 30. Name an laddress of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD, CLINTON, MARYLAND TERRY JUDRIE, MID. 31. Date filed (Month, Day, Year) 32. pagistrar's Signature State Registrar

			1 - For State Registrar	State of M	aryland / Depa	artment of H			giene () 5 Reg. No.	16611
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Anne Nu	ttall Sco	ott			MAY 11		1:30p M
	Examin		4a. Facility Name (If not institution, give :			4b. City, Town, or	Location of D	Death	4c. County of Deat	
			Anne Arundel Medi			Annar			Anne A	
ŀ	Funeral Director		5. Social Security Number 6. Security Number 215-30-9805	7. Ac	ge (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days		Min. B. Date of Birth (Month, Day DEC 21	, Year) 9. Birt Co , 1933 Mar	hplace (State or Foreign untry) yland
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
	Aaryli F sho	ō		timore						1 ☐ Yes 2 No
	28a-	Director	10e. Street and Number	cinore		Catons 10f. Zip Code	sviite		10g. Citizen of What Co	untry?
	3a or		300 Montrose Ave	nue		2	21228		USA	
	me 2	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	ispanic Origin	? (Specity Yes or No- Puerto Rican, etc.)		
36	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural; or iteme 23a or 28a-f show event, the Medical Exertine reset by notified at	by Fu	1 ☐ Never Married 2 Z Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1 Yes 2 If Yes, Give Year or Dates:	No.	1 ☐ Yes 2 ☐ No	Specify:	ruento Rican, etc.)		nite
9	2 hou		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ation	4 41	16b. Kind of Business/	Industry
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Ma	od 2 sollth an 27 is r		Thomas M. Scott/h			Montrose			.es 8e0.59809	10000
ē,	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	11e, MD 21 20c. Location - City or	
9	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Metro Cr	natory`or other plac ematory,		/13/05	Baltimore	, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and i Depertment of Health Important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service License	MO DEMU	22	Name and Address Crematio	ss of Eacility.	ety of Mar	yland, Inc	
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	D1		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ne cause on each l	ine.	2		. 100	ephythia	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	CANE	who	un (AI	Right	
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687	physics the l	dicai		J						
Box (	leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of deli	very
	ie death certificate be executed the attending physicien and hed for use as the buriat-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
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Records,	88 60 60	by	Part II. Other significant conditions cor	ntributing to death t	out not resulting in the u	nderlying cause give	en in Part I.		ibacco use contribute to 'es 2 □ No 3 □ Pri	1-1
000	> 0 0	Completed						24a. Was a autops	an 24b. Were au	topsy findings available completion of cause of
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Vital	ysicien: Th Is certificate director, pag	Be (	25. Was case referred to medical examiner?	/				Death (Check only or	ne)	
) t	slc dii	70	1 ☐ Yes 2 No	lospital: 1 Inpati			4 L 14013		ence 6 Other (Spec	cify)
uc.	ding F	tion:	27. Magner of Death  1. Natural 5 Pending investigation	28a. Date of Inju (Month, Da	ay Year) 28b. Time of Injury	Worl	γατ k? Yes 2 ∐ No		ow injury occurred	
Division of	Attending r death. sctor: After oy the fune	fical	3 Suicide 6 Could not be	28e. Place of In	jury - At home, farm, str			28f. Location (S	treet and Number or Ru	ral Route Number,
<u>S</u>	- 9	Certification:	4  Homicide determined	building, e	tc. (Specify)	•		City or Tow	n, State)	
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	dicai (	29a. Certifier Certifying Physics (Check only one)	sician: To the best ner: On the basis of and manner si	of examination and/or in	n occurred at the tim vestigation, in my o	ne, date and p pinion, death	place, and due to the coccurred at the time, co	ause(s) and manner as date and place, and due	stated. to the cause(s)
	orthin orthin	Me	29b. Signature and hitle of certifier	0 1 /	1	29c. License	e number	2	29d. Date signed (Monti	Day, Year)
			> / Froton Val	upp h	(homas )	Harrie	D AV	1864052	5/13/	51
1	O		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type,	Print)			1-1	
	,-		V		ne Arundel	Medical	Center	Annapo	lis, MD	
	Sta Registr		31. Date filed (Month, Day, Year)	. 0	rar's Signature	South )				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** eil Schlaa 01:41AM 12 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Columbia County General Hospital Howard If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 XM 2 ☐ F Director 215-44-0532 59 Maryland Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other than "naturel", or Items 23s or 28e-1 show other treumatic svent, tre Madical Examinar must ke notifical si 1 ☐ Yes 2X No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8670 Manahan Drive 21043 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21X No White Specify: Be Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Cabinet Maker Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fill f Health and Mental Histem 27 is marked oth Howard Irving Schlag Fay Cullen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patrick Von Schlag 12125 Early Lilacs Path; Clarksville Date Date 20c. Location C Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 5/17/2005 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Beltsville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) vice Lice See 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ougestive heart tailure **Physician** 2 years /Medical Examiner artery oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physiclan/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Dunknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🗌 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has certificate 1 Tes 1 ☐ Yes 2 NO No or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Medical Certification; To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗀 Inpatient 2 PER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manuar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Fo the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat tle of certifier D0050595 May 12, 2005 of person who completed cause of death (Item 23a) (Type, Print) 600 N. Welfe St, Baltmore, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 17 2005 Registrar

State of Maryland

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/ Department of Health and Men	tal Hygiene 0 0 5   6 6   3	
Certificate of Death	Reg. No.	

			Cei	rtificate of D	Death	Reg. No.	10013
	Physici	an	1. Decedant's Name (First, Middle, Last)	noitau	2. Date of D Month	Day Year	3. Time of Death
-	/Media	cal	4e Fecility Nema (If not institution, give street end number)	100	City, Town, or Location of Dae	th 4c. County of Death	11.33
d	Examir	ner	Lorien Nursing Home		Columbia	Howard	4
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey)	If Under 1 Year	If Under 24 Hrs. 8. Date of B		place (State or Foreign
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	pug 🗼		Usual Rasidance of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	fanyle	ក					1 ☐ Yes 2 <sup>X</sup> No
	the N	Director	Maryland Howard Colum	IND 1.8 10f. Zip Code		10g. Citizen of Whet Coun	itry?
	ath with the Maryler 23s or 28s-f show		6334 Cedar Lane	21	044	U.S.A	
	fter death r fterns 2 liner mus	Funeral			panic Origin? (Specify Yes or N , Mexican, Puerto Rican, etc.)		an Indian,
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a	D 20 0	TO B	Joseph E. McCutchan		Grace Shanks		
ary	S E E		19a, Informant's Name/Relationship (Type, Print) 19b. Mailin	ing Address (Street a	nd Number or Rurel Route Num	ber, City or Town, State, Zip	Coda)
	1 and 2 Haalth a sm 27 is					shington, DC	
Baltimore,	ges 1 and tof Haalt if Itam 2.		20a. Method of Disposition 1 ☐ Buriel 2 【 Cremation 3 ☐ Removal from Stata 20b. Place of Disposametery, crem	osition (Nama of emetory or other place	May 6,	20c. Location - City or To	wn, State
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ga	permit. P Departm Importar any Injui			2. Name and Address itzke Fune	of Facility ral Homes, Inc		
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	Examiner		disaasa or condition resulting in death)	7 912	tye		
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$\leq$	or Att	Certification:	4 Homicida  28a. Place of Injury - At home, farm, str building, etc. (Specify)	raet, factory, office		(Straet and Number or Rure own, Stete)	i Adule Number,
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this cartifical complataly filled in by the funeral director.	edical	(Check only one)  2 Medical Examiner: On the besis of examination and/or interest on the pesis of examination and/or interest.				
	within 2 To the compla	Me	29b. Signature and title of cartifier	29c. Licensa	number	29d. Date signed (Month,	Dey, Year)
			1	Ita	044183	5/12/05	•
	D.		30. Name end address of person who completed cause of deeth (Item 23e) (Typa,			1:-1-0	
	3		IRMA BENSINGER D.C.	5456	Knell North	Drive Suite	120
	Sta	02	31. Date filed (Month, Dey, Year)  32. Registrer's Signature	wer.		columbia	MD 21645
	Registr	ar	MAY 1 7 2005 Brown As 19	40			

	1 - State of Marylar Registrar	nd / Department of Health and I Certificate of Death	Mental Hygiene 0 05 16614
Physician	Decedent's Name (First, Middle, Last)     Mildred Mae	Schisler	2. Date of Death Month Day Year MAY 16 2005 3. Time of Death 5: 56 M M
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  North Arundel Hospit  5. Social Security Number 6. Sex 7. Age/(in yrs.	- CICIL DUITING	4c. County of Death Anne Arunde /
Funeral Director	500 22 0908 1 M 201 79	last birthday) If Under 1 Year If Under 24 Hrs.  Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 17, 1926 OK Lahoma
yland	Usual Residence of Decedent  10a. State 10b. County 10c. Ci	ty, Town or Location	10d. Inside City Limits
with the Mai	Maryland Anne Arundel (	Glen Burnie	1 ☐ Yes 2 <u>v</u> No
338 or	305 Chalmers Avenue	10f. Zip Code 21061	10g. Citizen of What Country?
and 21215-0036  Ind 21215-0036  be filed within 72 hours after death with the Maryland Alla Hygiene.  of other than "natural", or items 23a or 28e-1 show event, the Medical Exercites rivest to notifice at Be Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	.S. 13. Was Decedent of Hispanic Origin? (Single Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
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Ind 212 be filed with tital Hygiene of other than event, the A	12th 17. Father's Name (First, Middle, Last)		Own Home
Schisfer  more, Maryland 2 Pages 1 and 2 should be liled then to Health and Mental Hyg nt: If than 27 is marked othan ry or other traumatic evant,  To Be Co	Roy Kelley		resa Rose Hughes
OC his/F	Judith Fitzgerald / Daughter	,	ral Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21061
altimore, mit. Pages 1 ar partment of Hear portant: If Itam: y injury or other ca.			Date 20c. Location - City or Town, State
Baltimori Pemil. Pages Department of H important: If the any injury or of once.	' 4 □ Donation S □ Other (Specify)  21. Signature of Funeral Service Licensee		/2005 Baltimore, Maryland once Funeral Service, P.A.
w somma	Jesome grammanks	4001 Ritchie Highw	ay Baltimore, Maryland 21225
Physician	23a. Sant 1. Enter the disease for complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition is SCHEMIC	BOWEL MSEACE	or respiratory arrest, Approximate Interval Between Onset and Death
/Medical Examiner	resulting in death)  a. Due to (or as a conseq	uence of):	
Le de la company	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
8760, cate be executed physician and the burial-transit dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conseq	uence of);	
68760 cate be e physician the buria	d		
.O. Box 6 the death certific ty the attending y the attending to the as as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of do 9 □ Unknown	death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
Records, P The law requires that the has been signed be sage 2 should be deta	Part II. Other significant conditions contributing to death but not rest	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
COTC w requi			1 Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available
of Vital Records, Physician: The law requires t this certificate has been signe ral director, page 2 should be :: To Be Completed by			24a. Was an autopsy performed?  1 ☐ Yes 2 → No 1 ☐ Yes 2 ☐ No
of Vita Physician: this certific ral director.	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	Other	h (Check only one)
n ge life	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury at Work?	me 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
Division Control of the Hospital or Attanding Payin 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Medical Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At ho	M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Number
Dipital or pital or ours after prair illed in il			City or Town, State)
he Hosp in 24 hou he Fune pletely fil	(Check only one)    Check only one)   Check one)   Check only one)   Check only one)   Check one)   Check only one)   Check only one)   Check only one)   Check one)	wledge, death occurred at the time, date and place, tion and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
To ti within To ti com	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1/2	31 . Name and address of person who completed cause of death (Item		3 MAY 14, 2005
Y	blile leasshin - 2ELE k 31. Date filed (Month, Day, Year) MAY 1 7 2005 Registrar's Signal	E DESSE 11500 SUTHER	ELAND HILL WITH HVVER SPRING MD
Registrar	MAY 1 7 2005	17	20904

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For the design of the control of the	4		Physician		Immediate Cause (Final disease or condition Danc TC9 to Cance C				
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and fittle of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month Day, Year)  32. Legistrar's Signature  31. Date filled (Month Day, Year)  32. Legistrar's Signature  33. Date filled (Month Day, Year)  34. Legistrar's Signature  35. Legistrar's Signature  36. Legistrar's Signature  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  31. Date filled (Month Day, Year)  32. Legistrar's Signature		D O			Adopth Coul Venel 1-1	28d. Describe h	ow injury occurr	∍d	
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and fittle of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month Day, Year)  32. Legistrar's Signature  31. Date filled (Month Day, Year)  32. Legistrar's Signature  33. Date filled (Month Day, Year)  34. Legistrar's Signature  35. Legistrar's Signature  36. Legistrar's Signature  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  31. Date filled (Month Day, Year)  32. Legistrar's Signature		Ξ		rtiffi	determined 289. Place of Injury - At nome, farm, street, factory, office	28f. Location (S City or Tox	Street and Numbern, State)	er or Rural	Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  And Charles up 660 N. Charles St Baltwor w 21204  State  31. Date filed (Month Pay Year)  32. Segistrar's Signature			pital urs a aral D		200 Contilior				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  And Charles up 660 N. Charles St Baltwor w 21204  State  31. Date filed (Month Pay Year)  32. Segistrar's Signature			Hos 24 ho Fun Fun	dica	2 madical Examiner: On the basis of examination and/or investigation, in my opinion, death occi	e, and due to the ourred at the time, o	cause(s) and ma date and place, a	nner as sta nd due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  And Charles up 660 N. Charles St Baltwor w 21204  State  31. Date filed (Month Pay Year)  32. Segistrar's Signature			o the	Me	and married states.		29d. Date signed	(Month, E	Day, Year)
State 31. Date filed (Month Pay Year) 2005 32 egistrar's Signature			1170		MAK 121/200 Derror	V	nay 1	3 2	005
State 31. Date filed (Month Pay Year) 2005 32 egistrar's Signature		10	71/	2	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1	-	2
DESCRIPT FOR TRAINING TO A STATE OF THE PROPERTY OF THE PROPER		l			Apron Charles uno 6601 N. Charles SI	- realto	no lo	W)	4204
ALBERTALES TO A LANGE A CONTRACTOR OF THE PROPERTY OF THE PROP		:-			31. Date filed (Month, Day, Year) 32. egistrar's Signature				-

			1 - State Amend Item#14 Registrar	State of Maryla perFH, G843,	nd / Depa 5/27/05/	artment of Health and N tificate of Death	Mental Hygie	005	16616
П	Physici	an	1. Decedent's Name (First, Middle, Las				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		MAHNOOR NASP				MAY	5 2005	10:36 р. м.
	Examir	ner		street and number)  CENTER		BALTIMORE C	174	4c. County of Deat	h
	Funeral Director		-1/ 11	9x 7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.  4	8. Date of Birth (Month, Day, Ye	9. Birtl Co	hplace (State or Foreign untry) MD
	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation			10d. Inside City Limits
	Maryl f sho	ō	MD Balti			horpe			1 □Yes 2X No
	r 28a	Director	10e. Street and Number	more	narc	10f. Zip Code	10g.	Citizen of What Co	untry?
	h witi	a D	2678 Virginia	Ave		21227		U.S.A	i
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, If a Madical Estabilies must be indiffed at once.	by Funeral	11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Origin? (Springer, Specify Cuban, Mexican, Puerto Yes 2 XNo Specify:	pecify Yes or No- Rican, etc.)	14 Race - Ame	_
Ş	2 hou		15. Decedent's Ed		16a. Deced	lent's Usual Occupation	161	. Kind of Business/	Industry
21215-0036	within 72 iene.	Completed	(Specify only highest gra	College (1-4or 5+) N/A	(Give	kind of work done during most of work DO NOT use retired) nemployed	king	Unempl	·
	filed I Hyg other	0	17. Father's Name (First, Middle, Last)				e (First, Middle, Maid		1
Maryland	uld be Venta Irked Itic ev	To B	Najmul H. Tahi	r		Shamsa	Kanwal		
an	2 sho and h Is ma	ľ	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street and Number or Rui	ral Route Number, Ci	ty or Town, State, Z	ip Code)
	and ealth m 27		Najmul Hassan					orpe, Ma	21227
Baltimore,	ges 1 t of H If ite		20a. Method of Disposition  • Spurial 2 Cremation 3	Removal from State	-	natory or other place)		. Location - City or	,
Ë	tmen tent: tent:		Donation 5 ☐ Other (Specify			norial Park 5/1	16/05 Ra	andallst	own, Md
ga	permi Depa Impo any ir	ż	21. Seture of Funeral Service Licen	Shumpen	Ma	Name and Address of Facility Arch F/H West 300 Wabash Ave	Baltimo	ore, Md	21215
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the de- one cause on each line.					Approximate Interval Between
	Pnysician	1	Immediate Cause (Final disease or condition	a ANENCEP	HALY				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse					
		-	Sequentially list conditions,	b. Due to (or as a conse	Muonoo ofti				
-	ted nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence or).				
,	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	equence of):				
8/60,	e be o	dical	l	d					
9	tificat g phy as th	edi							
P.O. BOX	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of deli- Month	very Day Year
	s that ned b	y PI	Part II. Other significant conditions co	entributing to death but not re	sulting in the un	derlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
2	w requires been sig should be						1 ☐ Yes	2)ZNo 3 □ Pro	bably 4 Unknown
Division of Vital Records,	The law re ate has bee page 2 sho	Completed					24a. Was an autopsy performed	? death?	copsy findings available ompletion of cause of
<u>a</u>	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?			26. Place of Deat	1 ☐ Yes 2 h Check on one	10 103	-0.10
>	Physic this ce al dire	၉	1 ☐ Yes 2 🗷 No		☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 □Other (Spec	ify)
IOI C	ding I. After funer	atlon;	27. Manner of Death    Natural 5 ☐ Pending   Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how in	njury occurred	
DIVIS	after death after death Director: A d in by the f	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office	28f. Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phy 2 Medical Exam	vsician: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the time, date and place, estigation, in my opinion, death occurred	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and the of certifier			29c. License number	29d.	Date signed (Month	, Day, Year)
						D0057742		1AY 15,	2003.
	2		30. Name and address of person who c	ompleted cause of death (Ite	em 23a) (Type, F		-	, , , , , , ,	
	-		SHAHAB A MALIK				21225		
	Sta			32. Registrar's Sign	nature				
	Registra	ar	MALT ( SON)	Silver St.	A CONTRACTOR OF THE PARTY OF TH				

State of Maryland / Department of Health and Mental Hygiene 05

16617

_					Cei	rtificate o	f Death		Reg. No.	0 1	0017
	Discosio		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physic /Medi		HICE 141	ON				Month		2005	8.00 p.m.
3	Exami		4a. Facility Name (If not institution, give s	street end number)			4b. City, Town, or L	ocation of peeth			
			tuture CARE Hom	reincol			BALTIME	NE	N	Ta	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr.	s. lest birthdey)	If Under 1 Yea	ar If Under 24 Hrs.	8. Date of Birt	h , ,	9. Birthpla	ace (State or Foreign
	Director		418 26 9145 10	M 280 F	7 Yrs.	Months Dey	s Hours Min.	June 30	y, Year)	Counti	3)
			Usual Residence of Decedent		/			Saile 20	,19//		0.67
	danc		10a. State 10b. County	10c. 0	City, Town or Lo	cation				10	d. Inside City Limits
	Man,	ò	NA NA		BALFIMUN	16					1 ⊈Yes 2 □ No
	288	5	10e. Street end Number	3	74 14 1101	10f. Zip Code			10g. Citizen of N	What Count	n/2
	with a	ō	4	1							<b>y</b> :
	within 72 hours effer death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Modical Examiner must be notified at	Completed by Funeral Director	0,00,		110 401	215			0.5		
	er de	S		Was Decedent Ever in Armed Forces?	0,5.	Mas Decedent of If Yes, specify Cu	f Hispanic Orlgin? (Sp Jban, Mexicen, Puerto	Rican, etc.)	Blac	ce - America ck, White, e	
20	s eff	Y	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1□ Yes 25N	o Specify:		Specify	v: 0 ;	
8	in in in	d b	3√ Widowed 4 □ Divorced	Year or Dates:						Blace	.20
21215-0020	72 Inst	ete	15. Decedent's Educ (Specify onfy highest grede	ation completed)	16a. Deced	ient's Usual Occ kind of work dor	upation ne during most of work red)	king	16b. Kind of B	usiness/Indu	ıstry
2	ig o ga	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	Louse v	red)		House	P	
	filed w Hygie other ti	S	/0	0		Nouseu					-
5	tel H d off	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surnan	7 <b>e</b> )	
Sa	should I and Meni marke umatic	2	JAMES Shipman	<u>س</u>			DONA	UNKI	own		
Maryland	bue s	j,	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Stre	et and Number or Rui	rel Route Numbe	r, City or Town,	Stete, Zip (	Code)
_	end 2 salth e n 27 is	1	KrissEVELT TUNER	IR	200	7 CECII	I AVE BAIL	mong N	10 2/2	18	
<u>e</u>	S T E		20a. Method of Disposition	20b.	Plece of Dispo	sition (Name of	()	Dete	20c. Location -	- City or Tow	m, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show important if Items 27a or 28a-f show in Injury or other traumatic event, the Madical Examination or multiled at once.		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	mL. 7.12	1 Cêmen		5/20/10	RNL	NIME N	17
≣	in partie		21. Ignature of Funeral Service License		22	Name and Add	res of Facility 37	1001031	1)417111	WAS 1º	ID
Ba	permit. Departr Imports any inje										
			Sature Bu	b		1129 N.	CORNINE ST	BATHIN	ung MO	2121	3
			23a. Pert1. Enter the disease, or complic shock, or heert failure. List only on	eations that caused the de- e cause on eech line.	eth. Do not ente	er the mode of d	ying, such es cardiac	or respiratory ar	rest,	1	Approximate Intervel Between
Jan Service	Physician				1.	•					Onset and Death
4	/Medical		Immediate Ceuse (Final disease or condition		JAMA	MA				1	Unbrun
	Examiner		resulting in death)	Due to	(pr as a conseq	uertce of):	0 .				
	D #	Examiner		6	mil C	trunce (	end de	sleese			
V	cute	ш	Sequentially list conditions,	Due to	(or as a conseq	1					
Ó,	e exe	M	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.			•				i	
68760,	certificete be executed nding physicien end use es the buriel-trensit	Physiclan/Medical	thet initiated events resulting in death) Lest	Due to	(or as e consequ	uence of):					
	tifice ig ph es th	P	resulting in death) Lest							į	
ŏ	ndin use	Ş	3.								
ω,	d for	10.	Pert II. Other eignificant conditione cont	ributing to death but not re	scutting in the ur	adortuina anuna a	inon in Port I	22h Dide	obseco una co	ntribute to	the cause of death?
P.0	the y the	hys	M f	A	southing in the di	Idenying cause (	giveri ii i r eit i.		_/		
U.	The lew requires thet the death ete has been signed by the ette pege 2 should be deteched for i	Y	/134/	()					res 2□ No	3 - PIODS	ably 4 □ Unknown
sp	sign sign ld be	d by	, 1	100				24a Wes	en eutopsy	24b. Wer	e autopsy findings
Ö	peed	ete	(54)	ufen sun				perfo	med?	evai	lable prior to pletion of cause
ě	e lew has	Completed			2 0				/	of de	eeth?
=		ပိ		(earl	2 Cer			1 □ Y	es 2 No	1 🗆	Yes 2□ No
of Vital Records,	Physician: The larthis certificate har this certificate har this certificate har this stall director, page	Be	25. Was case referred to medical examiner?				26. Place of Deel	th (Check only o	ne)		
=	hysic nis c	2	1 ☐ Yes 2 Ø No	ospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatien	t 3□ DOA C	other: 4. Nursing Ho	ome 5□ Resid	ence 6 □Oth	er (Specify)	
_	ners	ᇊ	27. Manner of Death 1 □Natural 5 □ Pending	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj	ury et ork?	28d. Describe h	ow injury occur	red	
.0	Attending or deeth. ector: After by the fune	ati	2 ☐ Accident investigation				Tyes 2□No				
Division	Atte	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office	9	28f. Location (S City or Tow	treet and Numb	er or Rural	Route Number,
Ö	s efter self in the self in th	Certification:		Building, oto. (Opoo				on, o	., 0.2.0)		
	To the Hospital or Attending Phywithin 24 hours efter deeth.  To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier  (Check only 2 Medical Examin	cien: To the best of my kn	owledge, death	occurred at the	time, date and place,	end due to the o	euse(s) and ma	anner as sta	ted.
	n 24 n 24 ne F.	edicai	one) 2 Medical Examin	er: On the basis of examinand manner stated.	ation and/or inv	estigation, in my	opinion, death occur	red et the time, o	ate and place,	end due to t	ne ceuse(s)
	To the To the To the To the Comp	ž	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signe	d (Month, D	ey, Year)
			) // //	w			127569	1	5/11	1/05	
	Δ.		30. Name and address of person who con	poleted cause of death /Ite	am 23a) (Tyne i	Print)	1	<i>i</i> —	100	1 - /	
	7		111012	1HO AM IIA	Luar (1ype,	83X	Coreeine	T 120	041	21	Lost
	CI	10	31. Date filed (Month, Pay, Year)	32. Registrar's Sign	nature /	# n	,	, , , ,	V U	- (	7
	Sta Rogistr		MAY 1 7 2005	Maries 15	4000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** May 13, 2005 7:05 PM OPF! IEGFLE! /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Oay, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Yrs 217.12.9646 MARYL Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ir than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No KARKUILLE MS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 3117 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE 3 Widowed 4 Divorced 'natural' 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) other 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be Mental and Mental RITZGES OHN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PALKUILLE, MD 21254 AUBUST TacklownE 20b. Place of Disposition (Name of Date 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State cemetery, crematory or other place) injury or 17.2005 TARKUILE, MD 4 □ Donation 5 □ Other (Specify) YARKWOOD CENTERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans CHAPEL OF MEMORIES 8800 HARFORD RD. PARKUILLE, MD 21234 M01220 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PULMONARY EMBOLISM 20 minutes /Medical Due to (or as a consequence of) Examiner BREAST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit and certificate be exec Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Year 4☐ Pregnant at time of death 5 Other (specify) ☐ Yes 2 No P.O. been signed by the strongly be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by tachycardia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 No 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 No 1 XInpatient 1 Yes 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide or A 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0060632 May 13, 2005

State Registrar

DHMH 17 Rev 1/2001

MAY 1 7 2005

6701 N. Charles St

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



BENJAMIN HERMAN

MD

			1 - For State Registrar	State of M	aryland / Depa <i>Cel</i>	artment of F rtificate of I		ental Hygier Reg. I	6000	16619
H	Physic	an	1. Decedent's Name (First, Middle, Las AUDRE * L. THOMA	•				2. Date of Death Month	Day Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give			4h City Town o	r Location of Death	479 0	7 2005 4c. County of Death	8:25 PM
1	LAGIIII	iei	SINAI HOSPITAL	, 5,,55, 41,5 , 15,,,,55,,		BALTI			N/A	
	Funeral Director		5. Social Security Number 6. Social Security Number 1 06-30-0991 1  Usual Residence of Decedent	9X 7. Ag □ M 2 🖺 F	99 (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yei 12-29-1	9. Birthp Court MAI	place (State or Foreign
	anyland show		10a. State 10b. County		10c. City, Town or Lo	cation			1	0d. Inside City Limits
	ath with the Maryland 23a or 28a-f show	ctor	MD. N/A		BALTIMO	RE				1√ Yes 2 □ No
	with th a or 28 Lbe no	Dire	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Cour	ntry?
	death w	Funeral Director	1207 ETTING ST.	12. Was Decedent	Ever in U.S. 12.1	21217	ionania Orinia? (Can	-#. V N-	USA	
215-0036	- 2 W	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Å Year or Dates:	1	Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto f Specify:	Rican, etc.)	14. Race - Americ Black, White, Specify: BLA	etc.
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual Occupa	ation during most of workir f)	16b.	Kind of Business/Inc	
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	77/	OO NOT use retired DVISING	()		TRAME COUR	Dancora
d 21	Hygie Other ent, II		17. Father's Name (First, Middle, Last)	-2-	IAX A	DATSING	18. Mother's Name	(First, Middle, Maid	STATE GOVE	RNMENT
<u>Ilan</u>	ould be Mental arked o	To Be	WILLIAM W. WHIT	E			MARY WA		on comand,	
, Maryland	the man	2	19a. Informant's Name/Relationship (7) MARC THOMAS (SON)		19b. Mailin 20	g Address (Street a	AWN DR. AF	Route Number, City	or Town, State, Zip MORE, MAR	Code) YLAND 2120
Baltimore,	Pages 1 and 2 ent of Health a nt: If item 27 I: y or other tra		20a. Method of Disposition  1 Burial 2 Defending 3 1  4 Donation 5 Other (Specify,	Removal from State		Location - City or To	•			
Balti	permit. Page Department Important: If any injury or once.		21. Signature of Juneal Service Licens		ILLIPS FUNERAL HOME, P.A. ST. BALTIMORE, MARYLAND 2					
			23a. Part1. Enter the disease, or comp shock, of heart failure. List only o	lications that caused					, 11111	Approximate Interval Between
	Physician possented by Medical Examiner as the burial-transit	ш .	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Diab	a consequence of):  a consequence of):  a consequence of):	cara oscul	en Dic	ular Dis	eose	Onset and Death
P.O. Box 687	the death cer by the attendir ached for use	Physician/Medical	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal déath 3 ☐ l time of death 5 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
rds, ⊦	equires that en signed to ould be det	þ	Part II. Other significant conditions co.	ntributing to death bu	ut not resulting in the un-	derlying cause give	n in Part I.	23e. Did tobacco	use contribute to the	
l Records,	The law requiate has been age 2 should	Completed						24a. Was an autopsy performed?	prior to con death?	psy findings available apletion of cause of
VItal	Phyaician: Th	Be	25. Was case referred to medical examiner?		26. Place of Death		0 12103			
o	Ing After une	tion: To	1 Yes No Pending 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1  Inpaties 28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injury Work	4 Nursing Hom	e 5 Residence	6 Other (Specify, ury occurred	)
Division	al or Attending s after death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, stree (Specify)			Bf. Location (Street a City or Town, Sta	nd Number or Rural (e)	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	1	29a. Certifier (Check only one)  Certifying Physical Examination	sician: To the best oner: On the basis of and manner state	f my knowledge, death examination and/or inve ted.	occurred at the time estigation, in my opi	e, date and place, ar inion, death occurred	nd due to the cause( d at the time, date ar	s) and manner as stand place, and due to	ited. the cause(s)
	vithir To tr	Σ	29b. Signature and title of certifier  229 A	e.	M-D.	29c. License			ate signed (Month, D	
	9		Dugat A  30. Name and address of person who co  LIAQAT AL	mpleted cause of de	path (Item 23a) (Type, P	rint) st.	Baltin	nore M	D2/201	i
	Sta Registra	e ir	31. Date filed (Month, Day, Year) MAY 1 7 2005	2. Registra		20				

State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name /First Middle Last 3. Time of Death Пау Month Year **Physician** 15. Vasques May 2005 9:20 A Tulio /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8809 Arliss St. Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 24,1944 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** ₩ 2□F Days 577-70-0732 Director 60 Guatemala Usual Residence of Decedent Pages 1 and 2 should be tiled within 72 hours after death with the Maryland nent of Heatth and Mental Hyglene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State itam 27 is markad other than "natural", or items 23a or 28a-f show othar traumatic evant. It e Modical Examinar must be notified at 1 ☐ Yes 2▼ No Completed by Funeral Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8809 Arliss St. 20901 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☑ Married 2 XNo XYes 2□ No Specify: Guatemalan Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Program Coordinator Education 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maximiliano Vasquez Enriqueta Avendano 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosa Vasquez / Wife 8809 Arliss St., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) ö Department of important: if any injury or once. Chesapeake Crematory 5/17/05 Beltsville, MD 22. Name and Address of Facility
Rapp Funeral and Cremation Services 21. Signature of Funeral Service Lip Style Lohmann M00382 933 Gist Ave., Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4□Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1☐ Yes 2☐No 1 TYes 2 No Hospital or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🙀 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 XNatural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Diractor: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To tha the e 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ပ May 16, 2005 D0057304 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eirene Koroulakis M.D.; 10810 Connecticutt Ave., Kensington, MD 20895 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 1 7 2005

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) ROBERI **Physician** 0303 AM 6 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltinere Medical If Under 1 Year | If Under 24 Hrs. 9 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10 M 2□F 4 247-54-512 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Madical Examiner must be notified at 1 Yes 2 □ No Funeral Director Himore Varyland 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 1812 12. Was Decedent Ever in U.S. Armed Forces? Q 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry . Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 10n 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Pages 1 and 2 should be 0 ereen lle Srown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other p of Health a eres Vlason Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State = 5 Department o Importent: If any injury or 12005 emeter 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ave. Ba 23a. Part Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardionyopathi **Physician** uc /Medical Examiner Lena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Dav Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2□ No 1 Yes director. Medicai Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 🗌 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of after death. or Attending Natural 5 Pending investigation 2 No 1 Yes 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Leftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Division of Vital Records, P.O. Box 68760 completely filled in by the funeral within 24 hours a To the Funerel L

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

gerson who completed cause of death (Item 23a) (Type, Print) egistrar's Signature

ATTENDING

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar VENEY, HENAY

			For State Registrar	State of Marylan		artment of Hea rtificate of De			ene g. No.	05	166	22
	Physici		1. Decedent's Name (First, Middle,				2	2. Date of Death Month 5	Day	Year	3. Time of 8:45	
	/Medic	al	4a. Facility Name (If not institution,	VENEY		4b. City, Town, or Loc	ation of Death	2		2005 unty of Death	18:43	77 "
	Examin	ęr	GOOD SAMARITA	N HOSPITAL		BALTI	MORE			N/W		
Ē.	Funeral Director		237 36 1779	1. Sex 7. Age (In yrs. 74)	last birthday) Yrs.		Under 24 Hrs. 8 ours Min.	B. Date of Birth (Month, Day, May 6,/	Year) /	9. Birthp Cour	place (State o	r Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ecation				1	0d. Inside Ci	ty Limits
	a-fsh	to	MD	1/a BA	HIMORY	É					1 Yes	2 🗌 No
	or 28	Dire	10e. Street and Number	1		10f. Zîp Code		10	_	of What Cour	ntry?	
	s 23a	erai	5926 St. Reg	12. Was Decedent Ever in U.	S 13	21206	nic Origin? (Spec	ity Yes or No-	4.5	Race - Americ	an Indian	
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	1 and Health am 27 othar tr	1	20a. Method of Disposition	20b. F	293 Place of Dispo	psition (Name of matory or other place)	15 Reval	Doctions	Oc. Local	ion - City or To	own, State	
nor	Pages nent of I int: If its iry or o		1 Burial 2 □ Cremation : 4 □ Donation 5 □ Other (Spi	Hemovai from State	emetery, crei	natory or other place)  CEME FENT	1		-			
altimore,	permit. Pag Department Important: I any injury o	1	21. gnatur of Funeral Service L		21	2. Name and Adress of						
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	To the H within 24 To the Fi complete	M	29b. Signature and title of certifier	ARWAN M	. D.	29c. License nu		29		igned (Month,		
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	-		MARWAN AF	the completed cause of death (Iter	600D	SAMARIT	AN HOS	PITAL	-			
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			State of Maryland / Der 1 - State Amend Item 26 per verb., G843	partment of Health and Mei 5 (1-705) The Beath	ntal Hygiene	2005 16623
	2		1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day	y Year 3. Time of Death
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*	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c.	. County of Death
			BON SECOURS HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	BALTIMORE CITY  If Under 1 Year   If Under 24 Hrs.   8	Date of Birth	N / A  9. Birthplace (State or Foreign
п	Funeral Director		214-52-0385 1 M 27 F 54 Yrs.		1997 337 49	50   State of Poreign MARYLAND
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	hours after death with the Maryland lurel', or Items 23e or 28e-f show al Esantinet must be rediffed at	tor	MD 10b. County 10c. City, Town or BAL	Location TIMORE CITY		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Cit	tizen of What Country?
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	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ul> <li>Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric</li> </ul>	y Yes or No- an, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
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<u>α</u>	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
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Θ		Certification:	4 ☐ Homicide building, etc. (Specify)		City or Town, State	<del>)</del>
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edical	29a. Certifier (Check only (Check only Medicel Exeminer: On the basis of examination and/or	ath occurred at the time, date and place, and investigation, in my opinion, death occurred a	due to the cause(s)	) and manner as stated. I place, and due to the cause(s)
	To the within 2. To the complet	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Dat	te signed (Month, Day, Year)
	¥ 1 8 9		I Lamub A Singer, M. P			
,			30. Name and address of person who completed cause of death (Item 23a) (Typi	p. Print)  BON SECON	IRS A	MAY 10/65
	Sta	te				HI VIZ. 1
**.	Registr	-	31. Date filed (Month, Day, Year) 32. Registrary Signature MAY 1 7 2005			

		1 - For State Registrar		State of I	Marylar	•	artmen <i>rtificat</i>				ental Hy	gier Reg. M	200	5	16	624
		1. Decedent's Name (First, Mide	tle, Last)								2. Date of De	ath			3. Time	e of Death
Physi		Hugh K. Willia	mc								Month May 14		ay 2005	Year	9:34	1 PM <sup>№</sup>
/Med Exam		4a. Facility Name (If not instituti		street and numb	er)		4b. City,	Town, or	Location	of Death	May 14	7	c. County of	f Death		
Exam		Gilchrist Cent	er f	or Hosp	ice Ca	are			Towso	n		١,	Baltin	10 20		
Funera		5. Social Security Number	6. Sex	7.		last birthday)		1 Year	If Under	24 Hrs.	8. Date of Bir	th		9. Birth	place (Sta	te or Foreig
Directo		413-56-8339	1)3	M 2□F	67	Yrs.	Months	Days	Hours	Min.	(Month, Da			Coui	ntry)	
D		Usual Residence of Decedent														
anylan ehow		10a. State 10b. Coun	У		10c. Ci	ity, Town or Lo	ocation							1		e City Limits
be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural; or Iteme 23a or 28a-f show event, the Medical Exart as must be recibiled as	Director	MD Balt	imor	e	Մբյ	perco									1 🔲 Y	res 2 No
or 2	i.e	10e. Street and Number					10f. Zip	Code				10g. (	Citizen of W	hat Cou	ntry?	
23a	ie i	16627 Trenton	Road				21	155_				Un	ited	Stat	.es	
r deg	Funerai	11. Marital Status		12. Was Decede Armed Force	s?		Was Dece	dent of H	ispanic Ori	igin? (Spe	cify Yes or No Rican, etc.)	)-		- America, White,	can Indian	J <sub>a</sub>
afte or it		1 Never Married 2 Ma		1 ☐ Yes 2 If Yes, Give	No			2 No	Specify:		,		Specify:	,,	010.	
Jral',	d by	3 Widowed 4 Divorce	d	Year or Date	s:									Whit	te	
ed within 72 hours afi gjene. er than "natural", or , the Wedgel Exert.	Completed	15. Decede (Specify only high	nt's Edu	cation e <i>completed)</i>		16a. Dece (Give	kind of wo	rk done i	<i>durina</i> mos	t of workir	ng	16b.	Kind of Bus	siness/In	dustry	
within lene. than	l de	Elementary/Secondary (0-12)		College (1-4	or 5+)	life.	DO NOT u	se retired	1)			So	cial :	Secu	rity	
200	ပို				4	Manag	ger D	isab					minis		ion	
d 2 should be file th and Mental Hy I'l is marked oth treumatic event	Be	17. Father's Name (First, Middle	, Last)						18. Mothe	er's Name	(First, Middle	, Maid	e <i>n Sum</i> ame	)		
should be fand Mental I	2	Hugh M. Willia	ms						Doro	thy	Keller					
s 1 and 2 should be I Health and Mental tem 27 is marked other treumatic ev	4	19a. Informant's Name/Relation		•		19b. Maili	ng Address	S (Street .	and Numbe	er or Rura	l Route Numb	er, City	y or Town, S	State, Zip	Code)	
		Matthew William	ns/SC	NN	-	_			race		imore,					
Dermit. Pages 1 ar Department of Hea mportent: if Item iny Injury or other		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation	3 □□	amoval from Sta		Place of Dispo cemetery, crea	osition (Nai matory or c	me of other plac	(e)		ate	20c.	Location - (	City or To	own, State	)
Pages nent of ant: if it		4 Donation 5 Other		entoval nom ote		esapea	ke Cr	emat	orv		May 16 2005	Be	ltsvil	le,	Maryl	.and
permit. Pages Department of Importent: If It any Injury or or	ġ	21. Signature of Funeral Service	e License	90 L	89001	10 22	2. Name ar	nd Addres	ss ol Facili	ty						
	3	X H	lu	-	0001-						l Alter Drive			Ma	ww.1 a.w	a
_		23a. Part1. Enter the disease, shock, or heart failure. Li	or compli	cations that cau	sed the dea								CIMOLE	, ,	Approxir	mate
Physiciar		Immediate Cause (Final	st offiny of	ie cause on eac	_	1.0									Onset a	nd Death
/Medica		disease or condition resulting in death)	- a	n	as a conse	ctal	cas	nce	9/						Mon	ths
Examine				550.0 (0.	40 4 001100	qu'onico 01).										
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to (or	as a consec	quence of):										
uted insit	듵	cause. Enter Underlying Cause (Disease or injury	≺													
execu n and al-tra	Examiner	that initiated events resulting in death) Last		Due to (or	as a consec	quence ol):								-		
The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dicai		l.													
icate phy: s the	응															
eath certific attending p	Physician/Me	IF FEMALE:	2	3c. If yes, outco	me of prean	ancv							23d. Date	of daliv	an.	
eath cert attendin for use	ian	23b. Was decedent pregnant in the past 12 months?		1 ☐Live birt! 4 ☐ Pregnan	n 2 ☐ Feta	aldeath 3□	Ectopic p						Mon		Day	Year
at the de by the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1	9 Unknow		10atti 5	_ Other (sk									
that the od by detac		Part II. Other significant condi	ions con	ntributing to deat	h but not res	sulting in the u	nderlying o	ause div	en in Part I		23e, Did	tobacc	o use contri	bute to t	he cause	of death?
signe signe	i by			3		,g		J.,		•	10	Yes	2 XNo	3 □ Prob	bably 4	Unknowr
w require been si should l	Completed												- July 10			
e law has b	npidu										24a. Was	psy	pr	ior to co	opsy findin	igs available of cause of
	ပ္ပြဲ										1 Yes	2 X	No 1	eath?	2 No	
Physician: The law requires tribis certificate has been signeral director, page 2 should be con	Be	25. Was case relerred to medic examiner?								of Death	(Check only	опе)				
hysici this ce	2	1 ☐ Yes 2 No	Н	lospital: 1 🗌 Inp	atient 2	ER/Outpatier	nt 3 🗆 D0	Oth Oth	er: 4□NL	ursing Hon	ne 5□Resi	dence	6 Othe	r (Specil	y) Hos	pice
	ü	27. Manner of Death 1 ∠Natural 5 ☐ Pend	ina	28a. Date of I (Month,	njury Day Year)	28b. Time o Injury	1 2	28c. Injun Wor	y at k?	2	28d. Describe	how in	jury occurre	d		1
f or Attending after death. Director: After	atic	2 Accident inves	tigation				M		Yes 2	No						
for Att after de Direct	tific	3 Suicide 6 Could 4 Homicide deter	mined	28e. Place of	Injury - At h	nome, farm, str	reet, lactor	y, office		2	28f. Location ( City or To	Street wn. Sta	and Numbe	r or Rura	al Route N	umber,
	Certification;				, , . , . ,								,			
Hospitef 24 hours a Funerel I		29a. Certifier Certify	ing Phys	sician: To the be	est of my kn	owledge, deat	h occurred	at the tin	ne, date ar	nd place, a	and due to the	cause	(s) and man	ner as s	stated.	( )
To the Hos within 24 ho To the Fun completely f	Medical	(Check only 2 Medica one)	ıı Examii	ner: On the basi and manner	s or examina stated.	ation and/or in	vestigation	i, in my o	pinion, dea	ith occurre	ed at the time,	date a	ind place, a	nd due t	o the caus	<b>0</b> (S)
To the within 2 To the complete	Ž	29b. Signature and title of certif	er				29	c. Licens	e n <i>u</i> mber				Date signed			
		Hos. W	/(	200	?		ļ.	Do	05	792	6	M	ay 1	5,	200	5
		30. Name and address of person	n who co	mpleted cause	of death (Ite	m 23a) (Type.	Print)				6601 n					
10		Helen M.			wie		,				Towson				-1-661	
S	tate	31. Date liled (Month, Day, Yea		T	istrar's Sign	ature 🍎					LUWSUI	۱ و ا	ш. Z.1.Z	.04		
Ponic		100V 1 W	0005	7	L	Anga.	15 5									

			State of Maryland / Department o	•		
			1- State of Waryland / Department of Registrar Certificate of		2000	16625
	3	*	1. Decedent's Name (First, Middle, Last)	2. Date of L		3. Time of Death
	Physici /Medi		Sylvester Wilson	Month	Day Year	9:00 pm
	Examir	ner	0	n, or Location of Death	4c. County of Death	
κ.			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	THORE  our If Under 24 Hrs. 8 Date of F	Birth O Birth	place (State of Family
П	Funeral Director		218-10-8174 19M 20F 87 Yrs. Months Da			place (State or Foreign intry)
	p ,		Usual Residence of Decedent		, II GE	
	ahov ahov	'n	10a. State 10b. County 10c. City, Town or Location	,		10d. Inside City Limits 1 Stees 2 □ No
	the M	rect	MD BALTIMORE  10e. Street and Number 10f. Zip Coo	le	10g. Citizen of What Cou	
	be filed within 72 hours after death with the Maryland nat Hygiene. sd other than "natural", or Items 23e or 28e-f ahow event, the Medical Everther must be rediffed at	Funeral Director	1508 N. LOLFE STREET 21	213	U.S. A.	muy:
	ems 2	nera		of Hispanic Origin? (Specify Yes or Nouban, Mexican, Puerto Rican, etc.)	No- 14. Race - Amer	ican Indian,
36	or It	y Fu	1 Never Married 2 Married 1 1 Yes 2 No		Black, White	, etc.
21215-0036	hours tural	ed by	35 Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Oc		101	-ACK
215	within 72 ene. than "na	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ne during most of working	16b. Kind of Business/Ir	idustry
212	filed with Hygiene. Ither than	Com	12TH MOLDER		KOPPERS	GO.
nd	be file	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	le, Maiden Surname)	
yla	should be ind Mental marked c	70	POSTER WILSON, UK,	VELORES	CLARK	
Maryland	12 s h ar 7 la trau		19a. Informant's Name/Relationship (Type, Print)  DAUGHTER  19b. Mailing Address (Str.	eet and Number or Rural Route Num ERAVE, BASTO F		p Code)
	s 1 and 2 of Health item 27 other tra		20a. Method of Disposition  20b. Place of Disposition (Name or semelary, crematory or other		20c. Location - City or T	own, State
E	0 0		1 Surial 2 Cremation 3 Removal from State 4 Conation 5 Other (Specify)		ONINGS MILLS	s MD
Baltimore,	permit. Pag Department Important: I any injury o			dress of Facility  GREENE FUNERA		
	g Q E # 9		1/105 YO	PK RO BALTO, M	0 21212	
П			23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	tying, such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediane Cause (Final disease or condition resulting in death)  a	1 failine		54m
	Examiner		Due to (or as a mesquence of):	ten doing	y	
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	1 4 7 00 Section	^	
	acuted nd transii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	-	1	
760,	ate be executed sysician and ne burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
687	5 5	edical	d			
Box (	death certificat e attending phy id for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	erv
		Physiclan/M	in the past 12 months?  1  Yes 2 No  1  Yes 2 No		Month	Day Year
P.0	at the de d by the a etached	Phys	3 COUKUOMI			
	The law requires that the te has been signed by the sage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause CORONARY ARTERY DISEASE		l tobacco use contribute to t ] Yes 2 ☐ No 3 ☐ Proi	<u> </u>
Sor	v requii been s should	etec	HYPERTENSION			
Records,	The lav	ompleted	FIFEETERSION	24a. Wa auto peri	opsy prior to co formed? death?	opsy findings available impletion of cause of
Vital		e C	25. Was case referred to medical	1 ☐ Yes 26. Place of Death (Check only		2 □ No
of V	S S	To B	examiner 1 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA	Other: 4 Nursing Home 5 Res		(y)
o u	Ing P		Total of the state	Vork?	how injury occurred	
Division	Attending r death. ector: After by the fune	icat	3 Suicide 6 Could not be	☐ Yes 2 ☐ No	(Street and Mumber of True	/ Courte Muselle
Di≤	of or A after Direct	Certification:	4 Homicide determined building, etc. (Specify)		(Street and Number or Rure own, State)	al Houte Number,
	ospita hours uneral		29a. Certifier  (Check only 2 Medical Examiner: On the basis of examination and/or investigation in m	time, date and place, and due to the	e cause(s) and manner as s	stated.
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	<b>l</b> edical	one) and manner stated.			
	To To	Σ	29b. Signature/and title of certifier	ense number	29d. Date signed (Manth,	Day, Year)
,	<i>A</i>		20 Name of address of across who applied are a first the	0) 50/8	3/1/05	
	3		30. Name 3d address of person who completed cause of death (Item 23a) (Type, Print)	no Plane 1	alterna	141)21201
	Sta	4	31. Date filed (Month, Day, Year) 32. Degistrar's Signature	110		1
1	Registr	ar	MAY 1 7 2005 Rem & Spark			

Amend It State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23,25,27,28 amicarper Desug 6851,01/25/06dhb 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Year **Physician** 2330 Nathaniel Webster MAY 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X**□M 2□F Yrs. Director 214-72-8717 48 10/21/1956 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show items 23a or 28a-f shov 1 XYes 2 No Director Maryland Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3437 Dupont Avenue 21215 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter of nent of Health and Mental Hygiena.
nt: If item 27 is marked other than "neturel", or iten iny or other treumatic avent, the Muritial Expert in any or other treumatic avent, the Muritial Expert in any 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Randolph Webster Jean Barnes ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3437 Dupont Avenue, Baltimore, Maryland 21215 Jean Webster / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department of Importent: If any injury or once. Mt. Zion Cemetery 05/19/2005 ' 4 □ Donation 5 □ Other (Specify) Landsdowne, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. ture of Funeral Service Lice 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chenical Premantis 3 nors Aspiration /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on CERTIFICAT IN TOTALED BY MEDICAL EXAMINER Examiner requires that the death certiticate be executed burial-trans Due to (or as a consequence of): Box 68760. physician by Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death P.O. ed by the a detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ed bluods Diabetes, Remote head injuries, Malnutrition, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed S/P PEG placement 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s autopsy performed? of Vital 1 Yes 2 No 25. Was case referred to medical examiner?
1 Ayes 23. No. director. Be 26. Place of Death (Check only one) Hospital: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P this 28a. Date of Injury (Month, Day Year) 1985 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: Atter Division Hospitel or Attending 1 Alvatural 2 ☐ Accident 5 Pending after death. Unknown 1 Yes 2 No Unknown investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 🗌 Homicide building, etc. (Specify)
Unknown Unknown 24 hours a Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To tha Funa completely ti (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946 - ES MAY 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. University GULATI GALTAM PKWy Baltimore, MD 21218 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Sports MAY 1 Registrar 7 2005

			1 - For State of Maryland / Department of He Registrar Certificate of D	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Earl West	2. Date of Death  Month  Day  Year  May  12  25  May  Year  G35  M
	Examir Funeral Director		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or L  Check S. Social Security Number  6. Sex  7. Age (In yrs. last birthlay)  1 M 2 F  1 M 2 F  1 M 2 F  1 M 2 F  1 M 2 F	
	Aaryland f show	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits  #Yes 2 □ No
	with the Paror 28a-	Director	10e. Street and Number	10g. Citizen of What Country?
980	within 72 hours atter death with the Maryland ene. than "natural", or items 23a or 28a-f show is Medical Existing trivial te rolling at	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Pyes 2 No If Mes, Give 1 Yes, specify Cuban, 1 Yes 2 No If Mes, Give 1 Yes or Dates:	panic Origin? (Specify Yes or No., Mexican, Puerto Rican, etc.)  Specify:  14. Race - American Indian, Black, White, etc.  Specify: White, etc.
21215-0036	filed within 72 ho Hygiene. sther than "natur ent, I've Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1/4 or 5+)  College (1/4 or 5+)	ion 16b. Kind of Business/Industry  Administrator MTA
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, I.s. M.	To Be	James West	18. Mother's Name (First, Middle, Maiden Sumame) Adele Maverhof
Baltimore, Mar	1 and Health Iem 27		Shirley Wist  20a. Method of Disposition  1 (Burial 2   Cremation 3   Removal from State)  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltin	permit. Pages Department of Important: If it any injury or o		Symbolic G Salvally FVANSFORE	SALCHAPEL, SROHAPFORD RD
	Physician		23a. Pant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. Lift only one cause on each line.  Immediate Cause (Final disease or condition	such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
8760,	/Medical Examiner  ohysician and the purial-transit	dicai Examiner	resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
<u>α</u>	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I. 23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 2 Unknown
al Records,		Completed		24a. Was an autopsy performed?  1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 X No	26. Place of Death (Check only one)  4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Division of	tending leath. lor: After the fune	Certification; T	27. Manner of Death  1 X Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work?  2 Accident Investigation M 1 Year	at 28d. Describe how injury occurred
Divi	i i i i		4 Homicide determined 256. Place of injury - At nome, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or within 24 hours after To the Funeral Die completely tilled in	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	nion, death occurred at the time, date and place, and due to the cause(s)
)	T with	~	29b. Signature and title of certifier Attonoring Physician 29c. License of Physician	
12	417			153682 May 152005 13(vd.305 Baltimore 2123)
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 7 2005  32. Registrar's Signature	

			For Stete	State of Marylar		tment of Health and ificate of Death		2000	16628
			Registrar  1. Decedent's Name (First, Middle, Last	?)	Cen	ilicate of Death	2. Date of Dea	leg. No.	3. Time of Death
	Physici		James	A	1100	inht	Month	Day Year	12:00 P.M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of De	· · · ·	4c. County of Death	
			2104 Hackney	Ct.		Fallston		Harford	1
	Funeral		5. Social Security Number 6. Se	X 7. Age (In yrs.	4.0	If Under 1 Year If Under 24 h	lin. (Month, Day	, Year) Coun	lace (State or Foreign
	Director		Usual Residence of Decedent	<b>4</b> 23 .	Yrs.		4-7-	24 MAR	YLAND
	yland iow		10a. State 10b. County	10c. Ci	ty, Town or Loca	ation		1	0d. Inside City Limits
	Man Ba-f sh	ctor	MD Harfor	d	Fall	Ston			1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number	0.1		10f. Zip Code	1	log. Citizen of What Coun	ntry?
	ath w		2104 Hackney			21047		USA	
	ter de	Funeral	11. Marital Status  1 Never Married 2 Married	2. Was Decedent Ever in U	J.S. 13. W	as Decedent of Hispanic Örigin? Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - Americ Black, White,	
336	urs aff	by	3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	1[	Yes 2 No Specify:		Specify:	ملناه
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show the Modicol Examiter", and be notified	Completed	15. Decedent's Edi		16a. Decede	nt's Usual Occupation nd of work done during most of	working	16b. Kind of Business/Ind	dustry
2	ithin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. Do	O NOT use retired)	WOIKING	2 10 1	, ,
	fled w flygier her th		17. Father's Name (First, Middle, Last)		Jale:	s man	Name of Circle Adiabatic	Best Bout	tery co.
and	d be finital h	Be c	C1	ht 50		21	Name (First, Middle,		(
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "neturet", or Items 23a or 28a-1 show or other treumatic event. It is Modical Examiner in the netiting of the contract of the netiting of the contract of the netiting of the contract of the netiting of the contract of the netiting of the contract of the netiting of the contract of the netiting of the contract of the netiting	ပို	19a. Informant's Name/Relationship (T	o, Print)	19b. Mailing	Address (Street and Number or		r, City or Town, State, Zip	Code)
Š	nd 2 alth au 27 is r treu		Cindy O senbu	$\alpha$	2104	Hackney	Fallston	No. of the last	47
ore,	of Head		20a. Method of Disposition	20b. I	Place of Disposi	tion (Name of tory or other place)	Date	20c. Location - City or To	
<u><u>E</u></u>	Page nent ent: If ury or		1 Magurial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Terrioval itolii State	beney Vo	May Men Gar.	5-18-05	Timonium	QM n
Baltimore,	permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Funeral Service Licens	1 . 1	22.	Name and Address of Facility	BALTIMORE	5, mD 212	34.
	g ∪ ≥ 9 0		Brunely y.	Janosty	EVO	AS FUNCEALC	HAPEL, 88	MHARFORD	RO.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each line.	th. Do not enter	the mode of dying, such as card	liac or respiratory arr	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a_ Metali	750	Lyng CA	ovce	- I.	18 mon 14
	Examiner			Due to (or as a consec	quence of):	O			
	15 44 4	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec	quence of):				
	च ≔	~							
	cute nd rans	amln	that initiated events	c				ė:	
0,	e execute ian and urial-trans	Examine	Cause (Disease or Injury	C	quence of):				
8760,	cate be executed obysician and the burial-transit	dical	that initiated events		quence of):				
x 68760,		dical	Cates (Casass or hyar) that initiated events resulting in death) Last	Due to (or as a consected.				23d Date of delive	
Box 6	aath certific attending p for use as	dical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		ancy	ctopic pregnancy Other (specify)		23d. Date of delive Month	ory Day Year
.O. Box 6	death certific e attending p od for use as	dical	IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consect of the conse	ancy	ctopic pregnancy Other (specify)			
P.O. Box 6	that the death certific ed by the attending c detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consected	ancy al death 3 □E death 5 □ (	Other (specify)	23e. Did to		Day Year
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			1 - For State Registrar	State of Ma	ırylan		artment of I		nd Mental Hy	giene Reg. No.	05	16629
	Physici /Medio		1. Decedent's Name (First, Middle, & LIZABET		TE S	3 CI			2. Date of Do Month MAY	Day	2005	3. Time of Death
	Examir			TEALTH CAR			4b. City, Town, of	SVIL	18	BF		nore
	Funeral Director		5. Social Security Number 213–18–1769  Usual Residence of Decedent	_	(In yrs. I 88	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. B. Date of Bi	rth ay, 1916	9. Birtl	hplace (State or Foreign unity) Yland
	ryland how		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	the Ma 28e-f	ecto	Maryland N/A		Ba1	timore				10- 01	-4110	1 ☐ Yes 2 ☐ No
	h with	ai Dir	1400 E. Madison	Street, Apt	. 90	1	10f. Zip Code 21205	i		10g. Citizen USA	or what Co	untry ?
036	n 72 hours after death with the Maryland "natural", or iteme 23e or 28e-f ehow selfral Examinational be notified at	by Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? ad 1 Yes 2 N If Yes, Give Year or Dates:		-	Was Decedent of H f Yes, specify Cub	Hispanic Orig an, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)		Black, White	ncan Indian, a, etc. Lack
15-0	natur	eted	15. Decedent' (Specify only highest	s Education t grade completed)		(Give	lent's Usual Occup kind of work done	during most	of working	16b. Kind o	f Business/	Industry
2121	filed within Hygiene. other than ent, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		Room Sup		or	State	e of N	New York
Maryland 21215-0036	d la b w	Be	17. Father's Name (First, Middle, L	ast)	'			18. Mother	's Name (First, Middle	, Maiden Sun	name)	
ıryla	d 2 should th and Men 7 is marke treumatic	2	Plato 19a. Informant's Name/Relationsh	Hargr	ave	19b. Mailir	a Address (Street		ffie ror Rural Route Numb		anze wn. State. 2	Zip Code)
	5 € 7 ±		Celestine Cole-		_				altimore, l			
Baltimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation			emetery, crer	sition (Name of natory or other pla	ce)	Date	20c. Location		
altin	permit. Pag Department Importent: I any injury c		<ul><li>4 □ Donation 5 □ Other (Sp</li><li>21. Signature of Funeral Service L</li></ul>		100		Fremato Park Name and Addre		5/13/05 Loudon Pa			Maryland Home
ä	Deprin		1			100			ve., Balti			
R	25 15		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final	complications that caused only one cause on each lin	the death e.	. Do not ent	er the mode of dyi	ng, such as o	cardiac or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Due to (or as a	consequ	S \ S						V.
K	Examiner		Sequentially list conditions,				ELITIS					
	uted	Examine	Sequentially list conditions, if any, leading to immediate cause the conditions (Disease or injury that initiated events	Due to (or as a	consequ	ience of):						
,00	be executed sician and burial-transit		resulting in death) Last	Due to (or as a	consequ	ience of):						
68760,	ficate b physic s the b	edica		d.								
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	□ Fetal	death 3	Ectopic pregnanc Other (specify)	<i>y</i>			Date of deli Month	very Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant condition  DEMENTIA	ns contributing to death bu	t not resu	Ilting in the ur	nderlying cause giv	ren in Part I.		tobacco use c Yes 2 □ No		the cause of death?
of Vital Records,		Completed	ATRIAL FI	BRILLATIO	No				24a. Was auto perfo 1   Yes		b. Were au prior to death?	topsy findings available completion of cause of
Vita	Physician: 1 this certifical ral director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatier	ıt 2□F	ER/Outpatien	t 3 DOA Ott	100	of Death (Check only sing Home 5 Res		Other (Spec	rifu)
n of	ng Phy fter thi		27. Magner of Death  1	28a. Date of Injury	,	28b. Time of Injury	28c. Injui	y at	28d. Describe			ary)
Division	el or Attending Phys s after death. I Director: After this d in by the funeral di	Sertification;	2 Accident investig: 3 Suicide 6 Could n 4 Homicide determin	ation of be	ry - At ho	me, farm, str		Yes 2□N		'Street and Nu wn, State)	imber or Ru	ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best o xaminer: On the basis of and manner stat	examinat	wledge, death ion and/or inv	occurred at the ti	me, date and ppinion, death	place, and due to the coccurred at the time,	cause(s) and date and place	manner as ce, and due	stated. to the cause(s)
)	To the within 2: Within 2: To the complete	M	29b. Signature and title of certifier	inh PH.	1514	AM	, v	2723		29d. Date sig	12	2005
k	) (		30. Name and address of person w AVVERAHAL  31. Date filed (Month, Day, Year)	LI HARIS	1-1		RAC		NWOTES.	I WI	211	- 2
	Sta Registr	-4	MAY 1 7	2005 32. Registra	s signat	ure	artie)					

			For Stete Registrar	State of Ma	-	•	nent of H		ind Me		giene Reg. No.	05	16630
	Physici /Medio		1. Decedent's Name (First, Middle, Last, BENJAMIN WILSON						/	2. Date of Dea Month May	13, 2	005	3. Time of Death
	Examir	ier	4a. Facility Name, (If not institution, give  MARYLAND 076/N  5. Social Security Number 6. Security Number 6. Security Number 6.	eral H	ASPI to	e E	City, Town, or 2017/10 Juder 1 Year	Location of	Cr	Fy Date of Birt	4č. County	/ A	ce (State or Foreign
	Funeral Director		214-18-4960 Usual Residence of Decedent				nths Days	Hours	Min.	B. Date of Birt Month, Day 10-2-1	(24 <sup>ar)</sup>	MARY	LAND
	e Marylan 3a-f ahow diried at	ctor	MD. 10b. County N/A		10c. City, Town	or Location						10d	I. Inside City Limits  1 ∑Yes 2 □ No
$\mathcal{I}$	ath with th	ral Dire	10e. Street and Number 1620 N. PULASKI				of. Zip Code 21217				10g. Citizen of USA		
) / /5 07 5-0036	within 72 hours atter death with the Maryland ene. than "naturel", or Items 23a or 28a-f ahow he Medical Exartinat be treatled at	Completed by Funeral Director	11. Marital Status  1 □ Nøver Married 2 ☐ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates:			Decedent of His , specify Cubar es 2 No	spanic Orig n, Mexican, Specify:	jin? (Sp <i>e</i> c , Puerto R	ity Yes or No- ican, etc.)		ce - American ck, White, etc y: BLACE	C.
7 5	within 72 hours ene. than "naturel", he Medical Exe	mpleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) -12-		+)	(Give kind	Usual Occupa of work done d OT use retired)	urina most	of working	3	16b. Kind of B	usin <i>e</i> ss/Indus	
1/1/1 land 2	be filed ntal Hygi od othar	To Be Co	17. Father's Name (First, Middle, Last) GEORGE WILSON		l					First, Middle,	Maiden Surnan		
Jan,	77 - 7		19a. Informant's Name/Relationship (Ty LILLIAN M. WILSO			_					r, City or Town,		
2011 imore	1 to 6		20a. Method of Disposition 1 X Burial 2 Cremation 3 □F 14 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of cemetery GARRISC	Disposition y, cremator ON FOR	(Name of y or other place REST VE	reran	Da S 5-1		20c. Location OWINGS	•	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Closes	Albrei	<u> </u>	1721	-27 N.	MONR	OE SI	BALT.	IMORE,	MARYLA	AND 21217
	Physician /Medical		23a. Part   Enter the disease, or compl shock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. Arkr	ioscle	ROY		1.	eardiac or		rest,	ln ln	pproximate nterval Between Inset and Death
8760, %	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	consequence of conseq	a th	<i>y</i>						
P.O. Box 6	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	2 Fetal death		pic pregnancy ar (specify)	-			1	ate of delivery onth Da	
	w requires that been signed t should be det		Part II. Other significant conditions con	ntributing to death bu	t not resulting in	the underly	ring cause give	n in Part I.				tribute to the	cause of death?
Division of Vital Records,	: The law recate has be ; page 2 sh	Completed								24a. Was a autop perfor 1 🗌 Yes	sy mejd?	death?	y findings available eletion of cause of
of Vita	Phyaician: Th this certiticate al director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 You  27. Manner of Death	lospital: Inpatien			DOA Othe	r: 4 🗆 Nur	sing Hom		ence 6 Oth		
vision	Attanding Physic death.  ector: Atter this by the tuneral of tuneral of	Certification;	1 Sacident 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day	Year) In	ijury M		at ? ′es 2 □ N	10	8f. Location (S	ow injury occur		Route Number,
Div	ospital or A hours after inaral Direct y filled in by	al Cert	29a. Certifier 1 Certifying Physics	building, etc.	f my knowledge,	death occu	urred at the tim	e, date and	place, an	City or Tow	ause(s) and ma	anner as state	ed.
	To tha Hospital within 24 hours a To the Funaral I completely filled	Medical	(Check only one)  2 Medical Exemi	ner: On the basis of and manner stat	examination and	Vor investig	29c. License	number			date and place, 29d. Date signe		
	17/		30. Name and address of pers who co	impleted cause of de	ath (Item 23a),	Type, Print)		53		)	5/1	3/05	10
	Sta		31. Date filed (Month, Day, Year)	JWU, N.	r's Signature	0 %	Mary	lane	d (-)	renero	U A	LUSP I	tal
	Registr	ar	MAY 1 7 2005	Septime	N. A	BAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 6631 State of Maryland / Department of Health and Mental Hygiene [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BETTY WISE May 13, 2005 10:22pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Greater Baltimore Medical Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) JUL.21,1932 6. Sex Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 □ F Months Hours Min. 213-38-5791 Director 72 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 3512 AUTUMN DRIVE 21208 or Items 23a USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2X Married □Yes 2 X No 1 ☐ Yes 2 况 No Specify: Completed by WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SCH00LS permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) TEACHER BALTIMORE CITY & COUNTY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MILTON MAX ပ BERTHA WELLNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3512 AUTUMN DRIVE - BALTIMORE, MD 21208 SANDER L. WISE / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or BALTIMORE HEBREW CEM. 05/16/2005 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hypoxia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** oo tensio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Physician/Medical Examiner physician and s the burial-transit the Hospitel or Attanding Physician: The law requires that the death certificate be executed acidosis Due to (or as a consequence of): P.O. Box 68760, heart block IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2. No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Tes Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1. Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury s after dec. 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho To the Fun completely ( 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date, signed (Month, Day, Year) 2 who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

Registrar

7 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Month Month 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give-street and number) Examiner BALTIMORE OSSVIlle anor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Seb **Funeral** 1 □ M 2 1 F Yrs. MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10h County 10a State 7 is marked other than "natural", or Items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at 1 Yes 2 No BALTI MORE Funeral Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 2919 Pages 1 and 2 should be filed within 72 hours after death 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Lance 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental ! ဥ naymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trat once. 2919 Manas MD 21234 ALTIMORE H. 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Nom. Far 9-05 DALTIMORE. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BALTI MORE, MO 21234 21. Signature of Funeral Service Lice CHAREL, 8800 HARFERD RD EVANS FUNERAL ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one of Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certiticate be executed ed by the attending physician and detached tor use as the burial-tran Due to (or as Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifical 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 🗌 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

ne and address of person who completed cause of death (Item 23a) (Type, Print)

1

als G

32. Redistrar's Signature

PALI

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hyg  1 - Stata Registrar Certificate of Death	giene ag, No: 005 16634
1. Decedent's Name (First, Middle, Last)  2. Date of Dea	th 3. Time of Death
Physician Medical Helen Ann Allison April 2	23, 2005 PM
Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death
5405 Kirkwood Drive Bethesda  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	Montgomery
Funeral Director 5. Social Security Number 6. Sex 1. Age (in yrs. last birmoay) 1. Age (in yrs.	9. Birthplace (State or Foreign Country) 8,1917 Maryland
Usual Residence of Decedent	
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ★ Yes 2 □ No
MD Montgomery Bethesda  106. Street and Number 106. Street and Number 107. Zip Code	log. Citizen of What Country?
5405 Kirkwood Drive 20816	USA
9 2 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-	14, Race - American Indian,
Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)    Armed Forces?   If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   1   Yes 2 M No Specify:	Black, White, etc.
To a. State 10b. County 10c. City, Town or Location    To a State   10b. County   10c. City, Town or Location	Specify: White
15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired)	16b. Kind of Business/Industry
College (1-4or 5+) 4+ Interior Design	Home Interiors
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	Maiden Sumame)
Gordon W. Storke Eula Ann Holme	
1   Yes   2   No   Specify:   1   Yes   2   No   No   Yes   No   No   Yes   No   No   Yes   No   No   Yes   No   No   Yes   No   No   Yes   No   No   Yes   No   No   Yes   No   No   No   Yes   No   No   Yes   No   No   Yes   No   No   Yes   No   No   Yes   No   No   No   No   No   No   No   N	
Mary Bonhag /cousin 6 Pinebrook Ct., Silver Spring 20a Method of Disposition 20b. Place of Disposition (Name of Date	20c. Location - City or Town, State
Toe. Street and Number  10a. State  10b. County  MD  Montgomery  Bethesda  10c. City, Town or Location  10c. City Code  20cles  20cles  10c. City, Town or Location  Bethesda  10c. City, Town or Location  10c. City, Town or Location  10c. City Code  20cles  20cles  10c. City, Town or Location  10c. City, Town	·
21. Signature of Euneral Service Licensee 22. Name and Address of FacilityToseph Gaw1	
MO1378 5130 Wisconsin Ave. NW, Wa	
22a Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure.	est, Approximate Interval Between
Immediate Cause (Final disease or condition a Stroke	Onset and Death Months
Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate  b. Hypertension  Due to (or as a consequence of):	1 year
Due to (or as a consequence of):    Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):    Due to (or as a consequence of):	
resulting in death) Last Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  d.  Liphan Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting and control of pregnancy  1	
The part of the past 12 months?  23c. If yes, outcome of pregnancy  1	02d Date of delices
So that the past 12 months?  1	23d. Date of delivery  Month Day Year
O e the part II Other significant conditions contributing to death but not resulting in the underhips cause given in Ref I	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did to	bacco use contribute to the cause of death?
Severe Osteoporosis	es 2X No 3 □ Probably 4 □Unknown
Severe Osteoporosis  Severe Osteoporosis  Severe Osteoporosis  Severe Osteoporosis  Severe Osteoporosis  24a. Was a autops perform 1   yes a subspection of the summer of	prior to completion of cause of
	med? death? 2. XNo 1 ☐ Yes 2 ☐ No
1   Yes   2   Xes   Yes   2   Xes   Yes	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Na Reside 27. Manner of Death 28a. Date of Injury 28b. Time of Injury Work?	ence 6 ∐Other (Specify) ow injury occurred
D by G by G by G by G by G by G by G by	
1   Inpatient 2   ER/Outpatient 3   DOA	treet and Number or Rural Route Number, n, State)
O o la original o o o o o o o o o o o o o o o o o o o	
29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the concept of the	ause(s) and manner as stated. ate and place, and due to the cause(s)
25. Was case referred to medical examiner?  1	ause(s) and manner as stated, ate and place, and due to the cause(s)
D30844	ate and place, and due to the cause(s)
39 Name and address of person who completed cause of dearly from 23a (Type, Print)	ate and place, and due to the cause(s)  9d. Date signed (Month, Day, Year)  04/25/2005
12 Jeffice Jakes D30844	ate and place, and due to the cause(s)  9d. Date signed (Month, Day, Year)  04/25/2005

		Registrar			ertificate of	Dealii	F	Reg. No.		
Dhyaini		1. Decedent's Name (First, Midd	le, Last)				2. Date of Dea Month	ith Day	Year	3. Time of Death
Physicia /Medic Examin	al	JOSEPH 4a. Facility Name (If not institutio		RLES	ATKIN	SON or Location of Death	APRIL		2005	5:20 a.m
Lxamm	G,	DOCTORS COMMUN		,	LANHAM			PRINCE		RGE'S
Funeral Director		5. Social Security Number 103 34 6899	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last birthday 59 Yrs.	Months Day		(Month, Day	r, Year)		lace (State or Foreign etry)
	<u>}</u> -	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation		APRIL 2	9, 1946		YORK, NY
Maryla		MARYLAND PRINCE		HYATTS					"	1X Yes 2 No
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ehow int, the Mudical Evernitrat must be notified at		10e. Street and Number	S GEORGE 5	MINITO	10f. Zip Code			10g. Citizen of W	/hat Coun	ntry?
eath w	erail	2600 QUEENS CHA	APEL ROAD #.		Was Decedent of	20782	pacify Vac or No-	US 14 Bace		an Indian,
after dea or Itams	Fun	XXXXIX ever Married 2 Mar	Armed Force	ss? K) No		f Hispanic Origin? (S) uban, Mexican, Puert o Specify:	o Rican, etc.)		k, White, e	etc.
72 hours 'natural', dical Eva	ed by	3 Widowed 4 Divorced	Year or Date		1 ☐ Yes 2X N edent's Usual Occ		1	Specify.		BLACK
thin 72 e. en "ne Medic	Completed	(Specify only higher	st grade completed)  College (1-4	(Giv	e kind of work don DO NOT use retii	e during most of wor red)	king	160. KING OF BU	SITIESS/ITIC	Justry
e filed within Il Hygiene. other than vant, the M		12th			ENDOR	40 Markada Mara	(5: 14:	PRIVA		
ed al be	m	17. Father's Name (First, Middle, OSEPH ATKINSON	Last)				ne <i>(First, Middl</i> e, RNICE DEV		θ)	
d 2 should be th and Menta 7 Is marked traumatic ev	-	19a. Informant's Name/Relations	ship (Type, Print)	19b. Mai	ling Address (Stree	et and Number or Ru			State, Zip	Code)
s 1 and 2 f Health Item 27 I	-	ALVIN ATKINSON	/BROTHER	3007 20b. Place of Disp		RICE UPPER	R MARLBOI			2
9 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		20a. Method of Disposition  1 □ Burial 2 □ Cremation  1 □ Donation 5 □ Other (5		comotoni cri	ematory or other p	,	7-2005	Suitlan	•	
permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service				ress of Facility Man				
80E # 8		Samberry	MANAGE		4308 Sui	tland Road	<u>  Sultlar</u>	nd, MD	2074	5
Dhysisian		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	only one cause on eac	h line.				est,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or	as a consequence of):,	erw	ith Li	ver			
Examiner	-	Sequentially list conditions,	b. Due to (or	A Etasta as a consequence of):	es					1 month
cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 Acq	. 1	nmunoz	deficier	Ky Sy	ndron	re	6 years
be executed sician and burial-transit	ŭ	resulting in death) Last	Due to (or	as a consequence of):						
ificate g physias the l	edicai		d							
leath certifica attending pl		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom		□Ectopic pregnan	icy			of delive	
that the dea ed by the at detached fo	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow		Other (specify)			Mon	nin	Day Year
es that thighed by be detact	by Ph	Part II. Other significant conditi	ons contributing to deat	h but not resulting in the	underlying cause g	given in Part I.	23e. Did to	bacco use contri	bute to the	e cause of death?
w require been sig should b							100	es 2 🗆 No	3 🗌 Proba	ably 4 Unknown
has b	Completed						24a. Was a autops perfori	sy pi	ere autoprior to comeath?	osy findings available of cause of
Ician: The I certificate ha		25. Was case referred to medica	!			26. Place of Dea		2 <b>(1</b> No 1		2000
ding Physician: h. After this certific funeral director,	2	examiner? 1 ☐ Yes 2 No	Hospital: 1		int 3 DOA	ther: 4 \sum Nursing H	ome 5□Reside		r (Specify	')
ding P. h. After t funera	tion;	27. Manner of Death 1 DNatural 5 □ Pendir 2 □ Accident investi		njury 28b. Time Day Year) Injury	W	ury at ork? □Yes 2□No	28d. Describe ho	ow injury occurre	əd	
Attance of death of the by the	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At home, farm, s etc. (Specify)			28f. Location (Si City or Town	treet and Numbe	r or Rural	Route Number,
ital or urs afte ral Dir lled in										
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medicai	29a. Certifier 1 Certifyii (Check only 2 Medical one)	ng Physician: To the be Examiner: On the basi and manner	est of my knowledge, dea s of examination and/or is stated.	th occurred at the nvestigation, in my	time, date and place, opinion, death occur	, and due to the c rred at the time, d	ause(s) and mar late and place, a	ner as standard	ated. the cause(s)
To the within To the comple	Me	29b. Signature and title of certifie	7 00			nse number		9d. Date signed		
$\overline{n}$		* Ty coul	traval, M			482	P	tprik	,30	2005
		30. Name and add ss of person	who completed cause of		. Print)	Y Parki	NAY GO	eenbel	+ M	, 2005 1d.20770
			# P#11 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			1 1 1				

31 12		State     Registrar     Decedent's Name (First, Middle, Las	t)	Certificate of	of Death	2. Date of Dea	Reg. No.	3. Time of Death
Physici /Medic		Myrtle Lee Bro					26, Day 2005 Year	6:10 P
Examir		4a. Facility Name (If not institution, give Washington Adver	street and number) ntist Hospital		m, or Location of Death na Park		4c. County of Dea	
Funeral Director			7. Age (In yrs. last to 100	yrs. If Under 1 You Months Da	ear If Under 24 Hrs. hys Hours Min.	8. Date of Birth May 2,	9. Bir	thplace (State or Fore ountry) EXAS
wo		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location	1.5.1			10d. Inside City Lin
a-f sh lifted	ctor	Maryland Prince (	Georges Hyat	tsville				1¥ Yes 2□
23a or 28 at by no	Funeral Director	10e. Street and Number 7101 Marywood Str	reet	10f. Zip Coo 207			10g. Citizen of What C USA	ountry?
tems	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent If Yes, specify (	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Am Black, Whi	
ural', or i	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 No If Yes, Give Year or Dates:	1 □ Yes 2 □	No Specify:		Canait	lack
ledice	olete	15. Decedent's Ed (Specify only highest grad	ucation 16 de completed)	<ul> <li>Decedent's Usual Oc (Give kind of work do life. DO NOT use re</li> </ul>	ccupation one during most of worl stired)	king	16b. Kind of Business	/Industry
giene.	Completed	Elementary/Secondary (0-12)		Homemaker			Own Home	
Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at once.	To Be (	17. Father's Name (First, Middle, Last) Lee Allen				e (First, Middle, e Unk •	Maiden Sumame)	
ls mo		19a. Informant's Name/Relationship (7		b. Mailing Address (Str				Zip Code)
Health tem 27 other tr		Edith Egypt - Gra  20a. Method of Disposition		7101 Marywo of Disposition (Name of ery, crematory or other		ttsville Date	20c. Location - City or	Town, State
nent of part; If ite		1 Burial 2 Cremation 3 □ 14 Donation 5 Other (Specify	Tort 7	ery, crematory or other Lincoln Cem	place) netery 5/5	/2005	Brentwood,	
Department tmportent: I any injury o		21. Signature of Funeral Service Licens  Myselin T. Va	lobert	22. Name and Ad			ncoln FH	0722
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of		not enter the mode of	dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
ysician		Immediate Cause (Final disease or condition resulting in death)	a AFTVSKE.	seconotic	NORKET	DITTORS	4	Onset and Death
ledical aminer		resulting in death)	a. Due to for as a consequence	of):	e.cm	1 - 10		
بجد	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a consequence	ot).		042411		
and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	alkenoe.					
physician and s the burial-transit	cai		Due to (or as a consequence	A OFG	none CX7	Koness	7	
attending pl	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of de	liven
by the atter tached for u	Physician/M	in the past 12 months?  1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 Ectopic pregna 5 Other (specify			Month	Day Year
peug pe de	by	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
cate has been si page 2 should b	Completed					24a. Was a autop:	sy prior to death?	utopsy findings availa completion of cause
i≣ 'n	o o	25. Was case referred to medical			26. Place of Deal		2/2 No 1 ☐ Yes	2 □ No
this cert al direct	ToB	Tes 2 No	Hospital: 1 Inpatient 2 ☐ ER/C	dipatient 3 00A		ome 5 Resid	ence 6 Other (Spe	city)
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Director: A	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)			28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,
Funerel Funerel ely fillec	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sicien: To the best of my knowledginer: On the basis of examination a and manner stated.	ge, death occurred at th nd/or investigation, in n	e time, date and place, ny opinion, death occur	and due to the cred at the time, c	cause(s) and manner as date and place, and due	s stated. to the cause(s)
To the complet	Med	29b. Signature and tile of certifier -	and marrier stated.		ense number	2	29d. Date signed (Mont	h, Day, Year)
		1 / Kullee	en /	RUST	7614		4/26/0	25
2)		30. Name and address of person who con Dr. Don M. Colema	omplified use of death (Item 23a) n	(Type, Print)	a Park MD '	20912	1	
V 1/	1.4		/	rive, rancom	a rark m 2	-0712		

			For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of rtificate o		ınd Mental I	Hygier	111	)5	166	37
	Dhusisi		1. Decedent's Name (First, Midd.	le, Last)		<del></del>		2. Date o	f Death	ay	Vasa	3. Time of	f Death
	Physici /Medio		DOROTHY BIRCK	HEAD BROWN				May	1		Year 005	09:20	) A <sup>M</sup>
}	Examir	ier	4a. Facility Name (If not institution	n, give street and numbe	er)	4b. City, Town	, or Location o	f Death		c. County			
			Independence C  5. Social Security Number		g Home Age (In yrs. last birthday	Hyatts		04 Hrs. I a m		rince		rge's	
	Funeral Director		577-01-3604	1 M 2 M F	93 Yrs.	Months Day	s Hours		, Day, Yea	911	9. Birthi	place (State ontry) Land	or Foreign
	ס		Usual Residence of Decedent	1				Hay	14, 1	911	rialy	Tallu	
	unylan show	_	10a. State 10b. County		10c. City, Town or L	ocation					1	0d. Inside C	ity Limits
	8a-f.	Director		e George's	Adelphi							1 🗆 Yes	2 <b>X</b> No
	with th	급	10e. Street and Number			10f. Zip Code			10g. (	Citizen of V	Vhat Cou	ntry?	
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2-0	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show he Madical Examilier", ust be notified at	Completed	15. Deceder	it's Education st grade completed)	16a. Dece	dent's Usual Occ	cupation	of working	16b.	Kind of Bu		al Ass	
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2	iled v dygie ther t	Ö	12 17. Father's Name (First, Middle,	/act)	File	Clerk	10 14-45-	de blace o (Final Asi	WO	rkers			Pacc
and	d be f	Be c						's Name (First, Mic		n Sumam	Θ)		
<u>Z</u>	Shoull nd Me mark matik	은	Courtney Birck  19a. Informant's Name/Relations		19b. Maili	na Address (Stre		M. Brenn or Rural Route Nu		or Town	State Zin	Code)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Importants if item 27 is marked other then "naturel", or items 23e or 28a-f show any fujury or other treumatic event, the Macical Examinet or ust be notified at ance.		Douglas Newell	. Son-in-La				, Adelphi				0783	
J.	Pages 1 and 2 ment of Health a ant: If item 27 It ury or other tre		20a. Method of Disposition		20b. Place of Dispo			Date	-	Location -		wn, State	
Ē	Page nent c		1 🔀 Burial 2 □ Cremation `4 □ Donation 5 □ Other (S		Cedar Hi		۱ .	5-7-05	Su	itlan	d. Ma	arylan	d
alt	permit. Departr Imports sny Inje		21. Signature of Furtheral Service	Licensee				Gasch's H	uner	al Ho	me,	P.A.	
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ó	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Exa	resulting in death) Last	Due to (or a	is a consequence of):		7						
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Вох	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnan Other (specify)	ncy			23d. Date Mon	e of delive nth		∕ear
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Vital	ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place o	of Death (Check on		,		20110	
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Division of	ding P h. After i funera	ertification:	27. Manner of Death 1 ▼ Natural 5 □ Pendin		jury 28b. Time o lay Year) Injury	W		28d. Descri	be how inj	ury occurre	ed		
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<u>≥</u>	after Dire	ertii	4 Homicide determ	building,	njury - At home, farm, str etc. (Specify)	eet, ractory, onice	9	City or	Town, Sta	ng Numbe le)	r or Hura	Route Numb	ter,
	To the Hospital or Attending Physicien: which 24 hours after deals To the Funerel Director: After this certific completely filled in by the funeral director.	alc	29a. Certifier 1 1 Certifyin	g Physician: To the bes	t of my knowledge, deatl	occurred at the	time, date and	place, and due to t	he cause(:	s) and mar	nner as st	ated.	
	he Ho n 24 he Fu pletel	Medical	(Check ont) 2 Medical one)	Examiner: On the basis and manner s	of examination and/or in	vestigation, in my	opinion, death	occurred at the tim	ne, date ar	id place, a	nd due to	the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licer	nse number	( -	29d. D	ate ligned	(Month, I	Day, Year)	
}		14					561	4/	5	12	10	3	
)	(12)		30. Name and addr s of person				D 1	M	000	1	/		
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	Registra	_	MAY 0 3 20		I hose	w							

State of Maryland / Department of Health and Mental Hygiege 05 16638 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 28, 2005 4:30PM Charles Η. Bowles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days, Hours Min. Dec. 13, 1936 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2 F 233\*54\*2042 68 Cannelton, WV Director Usual Residence of Decedent with the Maryland orient: If item 27 is marked other than "neturel", or iteme 23a or 28a-f show injury or other treumatic event, its Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥Yes 2 No MD Prince George's Seat Pleasant 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 614 71st. Avenue 20743 United States death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No B1ack Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accounting Technician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h Pages 1 and 2 should be ment of Health and Menta Robert Bowles Mildred Hamlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Montzine Bowles/ Spouse 614 71st. Ave. Seat Pleasant, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Importent: If eny injury or once. Ft. Lincoln Cemetery 5/4/2005 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Lightsee 3401 Bladensburg Road Brentwood, MD 20722 Melyn nor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit the attending physician Box 68760 Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed .24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes the Hospitel or Attending Physicien: nin 24 hours after death. the Funeral Director: After this certified 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 /Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number o unosayeli 40009119 APRIL 29.2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1305 HADENER PARLED BY SUITE A GUEENBELT, MS 20170 MOSHYEDI 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2005 Registrar

December Name A Front Makes, Last   Samp Service Makes, Last   Samp Servi				For State Registrar	State	of Marylar	•	artment of H				giene	GUU.	166	39
Final Part					e, Last)						2. Date of Dea	ath		3. Time of	f Death
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Physician   Phys	<u>5</u>	s 1 ar f Hea item othe		20a. Method of Disposition		205.	Place of Dispo	osition (Name of	e)	D	ate	20c. Lo	ocation - City or T	own, State	
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Redical Examiner		Dhysisian		Immediate Cause (Final	only one cause on	each line.	F	ilure							
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25. Was case referred to medical examiner?  1   Yes   2   No		e death	sicis	1 ☐ Yes 2 No	4□Preg	nant at time of							MONTH	Day	T ear
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	R	(15)		D. 11 Page		use of death (Ite	m 23a) (Type	, Print)	A	чпар г	olic n	1d.	1		
					005	Registrar's Sign	nature	B)							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 26, . 2005 Year **Physician** Constance J. Blanchfield 14:00 р м /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 5795 Chesapeake Villa #216 Rock Hall Kent | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | February 21, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 100-24-0349 74 Yrs Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits treumatic event, the Modical Examiner must be notified at MD Director Kent Rock Hall 1 ☐ Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21661 USA 5795 Chesapeake Villa #216 or Items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 8m 27 Is marked other then "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Patterson Murray Josephine Hawkins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tree once. John Blanchfield/son 9232 Gue Road, Damascas, MD 20872 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Chesapeake Cremation | April 28,2005 STevensville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Fellows, Helfenbein & Newnam Funeral Home 130 Speer Road, Chestertown, Maryland 21620 Keck X 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Arterio Sclovetic Cardio Vascular Disease 4 4991 resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any local sequence cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial P.O. Box 68760, Physician/Medical use as the IF FEMALE. 23c. If yes, out*co*me of pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the a 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by Renal Insafficerion' Ostooporos 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral ( 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural s after dee. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled within 24 hours a (certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50996 person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature State Registrar

_			1 - For State Registrar		partment of Health and Nertificate of Death		iene) () 5 eg. No.	1664
1	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic		DOROTHY	BOSLER		April	30, 2005	7:5⊕P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Beverly Health	Care	Frederick  If Under 1 Year   If Under 24 Hrs.		Frederick	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda 2 2 F 82 Yrs.	// If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
			179-12-4115 Usual Residence of Decedent	02		July 16	, 1922   Per	nsylvania
	yland		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Mar Mar	tor	Maryland Frederi	.ck Free	lerick			1⊌ Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Cou	intry?
	23a	al	23 Fiarview Av	e.	21701		United Sta	ites
	r dea	Funeral		fas Decedent Ever in U.S. 13 med Forces?	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte , or h	<b>by</b> Fu	a If	☐ Yes 2/ No Yes, Give	1 ☐ Yes 2 ☑ No Specify:			
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show dical Ezationer must be confilled at	a pa	3 Widowed 4 □ Divorced Ÿ  15. Decedent's Education	ear or Dates:	edent's Usual Occupation		16b. Kind of Business/li	ite
5	in 72 n "na dedic	Completed	(Specify only highest grade com	pleted) (Gir	re kind of work done during most of work  DO NOT use retired)	king	Tab. Killa of basilless/il	loustry
212	filed within Hygiene. other than "	mo	Elementary/Secondary (0-12) C	ollege (1-4or 5+)	Homemaker		own home	
פַ	be file Ital Hyg Ind othe avant,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, M	Maiden Surname)	
Maryland	2 should be filed withir and Mental Hygiene. Is markad other than aumatic avant, th. M.	To	Walter S.	Hall	Marg	aret P	. Powe11	
lar	and and is ma		19a. Informant's Name/Relationship (Type, P		ling Address (Street and Number or Run	ral Route Number,	City or Town, State, Zi	p Code)
	1 and 2 Health am 27 othar tra		Jill B. Cejka/ Daugl		4 Stone Ridge Dr.	-		.702
Baltimore,	r iii		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ Remov	ral from State	ematory or other place)		20c. Location - City or T	
Ę	tt. Partmer rtant: njury	W	<ul> <li>4 ☐ Donation 5 ☐ Other (Specify)</li> <li>21. Signature of Funeral Service Licensee</li> </ul>				rederick,	
Ba	permit. Page Department Important: If any injury o		30 4 Ass		22. Name and Address of Facility St			
			23a. Part1 Enter the disease, or complication		1621 Opossumtown p			ZI/UZ Approximate
В			shock or heart failure. List only one can Immediate Cause (Final	use on each line.	1.0			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	Morse			2 weeks
	Examiner			Now ourset	etral Lebulle	elion		Queels
	n .=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			-	- wess
	acute nd trans	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.		<u> </u>			
90,	cate be executed physician and the burial-transit	Ě	resulting in death) Last	Due to (or as a consequence of):				
8760,	physic the b	Physician/Medical	d					
9 X	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	/Me	IF FEMALE: 23c. If	yes, outcome of pregnancy			23d. Date of deliv	07/
Box	atter of for u	ciar	in the past 12 months?	Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		Month Month	Day Year
0	the d by the achec	hysi		Unknown				
<u>ر</u> ت	s that pred to e det	by P	Part II. Other significent conditions contribut	ing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	he cause of death?
ğ	w require been sig should b	ed	Hyperlenous,	Type 2 du	fretes,	1 ☐ Ye	s 200 3 Pro	bably 4 Unknown
Vital Records,	e law re has be je 2 sho	Completed	Os teo arthuit			24a. Was ar		opsy findings available ompletion of cause of
œ —		Com				perform	ned? death?	2 No
/ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one	8)	
	Physic this o	2	1 ☐ Yes 2 ☐ No Hospit	1 ☐ Inpatient 2 ☐ EH/Outpati			nce 6 Other (Speci	fy)
ž (	After I	lon	. Littatara: 0 Littaling	a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe ho	w injury occurred	
isic	or Attanding latter death. Director: After in by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	e. Place of Injury - At home, farm, s	M 1 Tyes 2 No	28f Location (St	reet and Number or Rur	al Pauta Number
Division of	after Direction by	Certification:	4 Homicide determined 28	building, etc. (Specify)	певі, таскогу, опісе	City or Town	, State)	ar noute (varrider,
_	pita ours eral		29a. Certifier 1 Certifying Physician	: To the best of my knowledge, dea	ath occurred at the time, date and place,	and due to the ca	use(s) and manner as s	stated.
	80 0 0 0		(Check only 2 Medical Exeminer: C	on the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occur	red at the time, da	ate and place, and due t	o the cause(s)
	he Hospital n 24 hours: ha Funeral oletely filled	edical	,	/ 1// /				
	of a second	Medic	29b. Signature and ville of ceptifier	1/ 14	29c. License number	25	9d. Date signed (Month,	Day, Year)
)	To the Hos within 24 hc To the Fun completely	Medic		howalter	29c. License number 3 5 7 8	3	9d. Date signed (Month,	Day, Year)
)	To the Hos within 24 hc To tha Fun	Medic		ad cause of death (Item 23a) (Type	10 D3518	3 /	Pod. Date signed (Month.)  May  2	Day, Year)
	`	Σ	29b. Signature and vitle of certifier  30. Name and address of persop who completed	whiteh 300	10 D3518	3 / F	Pade signed (Month, May 2  Paderick	Day, Year)  1 205  MO
		te	29b. Signature and vitle of certifier	32. Registrar's Signature	10 D3518	3 / F	Pade signed (Month)  May  Pader tek	Day, Year)  ACOS  MO

			For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>			eg. No.	15	16642
	O		1. Decedent's Name (First, Midd.			Timouto of E	Journ	2. Date of Deat	th	Yeer	3. Time of Death
	Physici /Medi	cal		fe Cipolloni		1		May 2,	2005		16:25 рм
	Examir	ier	4a. Facility Name (If not institution Chestertown Nu				Location of Death COWN		4c. County Ken		
	Funeral Director		5. Social Security Number 219-01-0361	6. Sex 7. Ag	86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August 1	2,1918	9. Birthp	lace (State or Foreign try)
	land ow		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary a-f sh	tor	MD Kent		Chestert	own					1 ☐ Yes 2 🛣 No
	or 284	Olrec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of \	What Cour	itry?
	s 23a	rall	306 Cedar Str	eet 12. Was Decedent	5 min II C	21620	in Orieina (C	-4- V N-	USA	e - Americ	an Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Mar  3 XWidowed 4 Divorced	ried 1 Yes 2 X	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 💢 No	spanic Origin? (Spen, Mexican, Puerto	Rican, etc.)		ck, White,	etc.
21215-0036	72 ho natur dical	eted	15. Deceder (Specify only highs	nt's Education est grade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation Juring most of worki	ng	16b. Kind of B	usiness/In	dustry
121	within ane. than	mple	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired tist	)		Arts		
<b>d</b> 2	Hygie Other ent, I	Be Co	17. Father's Name (First, Middle,	Last)	7410	136	18. Mother's Name	(First, Middle, I			
/lan	uld be Vental Irkad Itic av	To B	Smallwood Leaf	Wolfe			Pearle C	asson			
, Maryland	alth and A		19a. Informant's Name/Relations Melville Wolfe			ng Address <i>(Street a</i> б Cedar St					
Baltimore,	Pages 1 and of He ant: If itam		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (5			osition (Name of matory or other place Park Ceme	e)		20c. Location - Baltimo		
Balti	permit. Departn Imports any injt		21. Signature of Funeral Service	Licensee		2. Name and Addres 2110WS, Ho 30 Speer	elfenbein Koad, Che	& Newna	am Fune	ral F Tand	lome P.A. 21620
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a		ter the mode of dying					Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edical		d	a consequence on).						
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 ☐ Yes 2 BNo 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (s <i>pecify)</i>				te of delive	ory Day Year
	w requires that been signed b should be deta		Part II. Other significant condition in the lines of the	Demon +12	out not resulting in the u	inderlying cause give	en in Part I.	23e. Did tot 1 ☐ Ye	- \/		ne cause of death? ably 4 □Unknown
Division of Vital Records,	ding Physicien: The law re h. After this certificate has be funeral director, page 2 sh	Completed by						24a. Was a autops perform 1 - Yes 2	y ned?	Were auto prior to cor death? 1 ☐ Yes	psy findings available inpletion of cause of
Vita	sicien certifii rector	Be c	25. Was case referred to medica examiner?	Hospital		Othe	26. Place of Death		4		
of	Physer this eral di	n; To	1 Tes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b. Time o	IL 3 DOA	42 Naursing nor	ne 5 ∐ Reside 28d. Describe ho			()
ion	anding ath. or: Afte	atlo		igation	y Year) Injury		res 2 □No				
Divis	iel or Atta s after de al Directo	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Flace of Inj	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Numb n, State)	er or Rura	l Route Number,
	To the Hospitel or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical (	(Check only Z Medical one)	ng Physicien: To the best Examiner: On the basis o and manner st	f examination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)
	with Tot	Σ	29b. Signature and title of certifie	1/1		29c. License			9d. Date signe		Day, Year)
,			Jusir	1 Kylis	100,		036		5/3/05		
			50. Name and address of person	who completed cause of c	leath (Item 23a) (Type, W & Shing to	rint)	hestertoro	a Mel.	21620	)	
:	Sta		31. Date filed (Month, Day, Year,	32. Region	ar's Signature			, , , ,			
	Registr	ar	MAY	0 4 2005	down A	(A.S. S. S. S. S. S. S. S. S. S. S. S. S.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 115 1- State Registrar 5/4/05, B.A.G., Kent Co. Certificate of Death Amended #17. Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** 090300 28 ummina /Medical 4c. County of Death Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Nuising hesterto Year If Under 24 Hrs. Kehabanter 4 8. Date of Birth (Month, Day Year March 26, Birthplace (State or Foreign Country)
 MD Social Security Number 6. Sex Age (In yrs. last birthday) 6° 1917 **Funeral** Days Min 215-05-804 1 M 2 F 88 Yre Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County or 28a-f ahow traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2X No Kent Chestertown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number WITH 118 Malone Ave. 21620 USA Items 23a death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No ō Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assembly WOrker Automotive pelil 17. Father's Name (First, Middle, Last) Wilbur Horace Mench 18. Mother's Name (First, Middle, Maiden Sumame) ages 1 and 2 should be fill ont of Health and Mental Hit: If item 27 is marked off y or other traumatic evan Be Charles Walter Mary Elizabeth White 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 118 Malone Ave. Chestertown, MD 21620 Delos Cummings, III/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Acremation 3 Removal from State Chesapeake Cremation May 2,2005 Stevensville, MD permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, CHestertown, Maryland 21620 21. Signature of Funeral Service Lice Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physicien for use as the burial Physician/Medical 98 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day 4☐Pregnant at time of death 5 Other (specify) o. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 2 No 3 ☐ Probably 4 ☐ Unknown 1 □ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Vital Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient Other: 1 ☐ Yes 2 ☑ No 3 DOA 4 V Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 After this funerat 28b. Time of 28c. Injury at Work? 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident within 24 hours after death To the Funeral Diractor: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only 29d. Date signed (Nonth, Day, Year) 29b. Signature and title of certifier 29c. License number Pate 30. Name and address of perion who completed cause of death (Item 23a) (Type, Print) Shanahan 120 Socar RD
31. Date filed (Month, Day, Year) a 32. Peg State

DHMH 17 Rev 1/2001

Registrar

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2 2005

				partment of Health and Mertificate of Death	lental Hygi	ene 005	16644
			1. Decedent's Name (First, Middle, Last)	Entineate of Death	2. Date of Death	g. No.	3. Time of Death
	Physicia		Grace Adelia Crouse		Month	Day Year 3:36 M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	11.04	4c. County of Death	
	Exam.		Washington County Hospital	Hagerstown	$\neg$	Washi	naton
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	9 Birth	nplace (State or Foreign
	Director		408−18−6695 1 M 2 F 86 Yrs.  Usual Residence of Decedent		Jul 25,	1918   Ten	néssee
	land ow		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Z should be liled within 72 hours after death with the Marylan and Mential Hygiene. and Mential Hygiene. I see is marked other than "natural", or liems 23a or 28a-f show eumatic event, the Madical Examinat must be multiped at	tor	PA Franklin Wayn	esboro			1 XYes 2 ☐ No
	h the	irec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	th wil	Funeral Director	36 W. Sixth St.	17268		USA	
	tems	nue	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	<ol><li>Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.</li></ol>		No- 14. Race - American Indian, Black, White, etc.	
20	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: [	√hite
9	filed within 72 hours after death with the Maryland Hygiene. Hysiene than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be nuffied at	edt		cedent's Usual Occupation		16b. Kind of Business/Industry	
2 2	hin 72 n "na n "na Medi	Completed	(Specify only highest grade completed) (Gi  Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of work . DO NOT use retired)	ing		
7	d with	E OC		Homemaker		Own home	e
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ă	Per Per Per Per Per Per Per Per Per Per		* ( franctie M. N/00rc	50 S. Broad St. Wa			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between				
			Immediate Cours (Final		accid		Onset and Deeth
			resulting in death)  Due to (or as a consequence of):				
		_	Sequentiary list conditions, if any, leading to immediate Due to (if is a consequence of):	1			y erm
	led Isit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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-	00 2, 00	cal	d				
	leath certificate   attending physi						
ROX	th cer tendir vr use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	∃Ectopic pregnancy		23d. Date of delivery	
	e dea the at ned fo	sici		Other (specify)	Month Day Year		Day Tear
f Vital Records, P.O. Box 68	res that the de signed by the a I be detached f	Ph)	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  239. Did tobacco use contribute to the cause of death?				
	signe d be	d by	Provides isclemiz comed usch accident 1 yes 2 No 3 Probably 4 Unknown				
	w require been significant	ete	24a. Was an 24b. Were autopsy findings availa				
	The la cate has page 2	Completed	autopsy prior to completion of cause performed? performed? death?				
		ø	25. Was case referred to medical	26. Place of Deat	1  Yes 2 h (Check only one		2 LJ N0
	nysici nis ce direc	To B	examiner?  1 Yes 2 No				
JIVISION OF	Attending Physicien: or death. ector: After this certifica by the funeral director.		27. Manner of Death  1				
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₹	or Attendater death Director: In by the	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,	eet and Number or Hu , State)	rai Houte Number,
_	To the Hospital or At within 24 hours after of To the Funerel Directompletely filled in by		29a. Certifier 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	e Ho:	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, da	ite and place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	1	d. Date signed (Month	n, Day, Year)
			1 may	D002081	3	5/9/00	
	1		30. Name and address of person who completed cause of death (Item 23a) (Typ		i /		2771
Nell OMalley - Hopprotissinal Ct Suite ( Itagystvan, MD II							0 11740
	Sta Registr		31. Date filed (Month Pay Year) 32. Togistrar's Signature	land &			negotian da
			JURINI JO				

Registrar

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31. Date filed (Month, Day, Year)

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32. Hegistrar's Signature

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pe execni		ician and	burial-transit	
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed		X To the Funeral Director: After this certificate has been signed by the attending physician and	completely fillad in by the funeral director, page 2 should be detached for use as the burial-transit	
n: The law requires t		ficate has been signs	or, page 2 should be o	
Attending Physicie	r death.	ector: Aftar this certi	by the funeral director	
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1 - State Registrar					Cei	rtificate	e or L	<i>Jeatn</i>			Reg. No.			
1. Decedent's Nar	ne (First, Middle	, Last)								2. Date of De	ath Day	v \	Year	3. Time of Deal
W	ilbur V	/erl F	orney							May 2				1:42 A
4a. Facility Name		-				4b. City, 1			of Death			County of		
	ick Memo						derio	CK If Under	Od Hea	- 15		Frede		(2)
5. Social Security 215-14-4		6. Sex 1 M 2 D		85	last birthday) Yrs.	Months	Days	Hours	Min.	B. Date of Bir (Month, Date)	1919 1919		Country, Marv1	
Usual Residence									F.	ay 14,	1713		maryr	and
10a. State	10b. County			10c. City	y, Town or Lo	ocation							10d.	Inside City Lin
Maryland	Freder	cick		Fr	ederio	ck								1 ☐ Yes 240∑
10e. Street and N	umber					10f. Zip	Code				10g. Citi	izen of Wh	hat Country	?
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19a. Informant's			nt)			•				Route Numb				ode)
John V.		Son		201 7				Cou		rederi				
20a. Method of Di	isposition 2  Cremation	3 □Remova	I from State	٥	Place of Dispo	matory or of	ther place		Da				City or Town	
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21. Signature of	uneral Service	Licensee			22	<ol><li>Name and</li></ol>	d Addres	s of Facili	ty c+.	. C.C	Fun	eralH	lome,	PA
	1 1	+					a Addi Os		Sta	uiier	I GII			
D.	). Ho	nton		d the death	1	62I 0 <sub>I</sub>	possi	umtow	m Pik	e. Fr	eder:			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month <sup>Day</sup>, 2005 **Physician** FRED PHILLIP FOSTER 10:01PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

5.0 Yrs Months Days Hours Min. 8. Date of Birth (Month, Day, Y June 10, 9. Birthplace (State or Foreign **Funeral** . 1945 Connecticut **™** M 2□ F 228-58-7053 59 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f show itam 27 is marked other than "natural", or itams 23a or 28a-f shov other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Frederick Monrovia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4979 Linganore View Drive 21770 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 □ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Vietnam 1 ☐ Yes 2 🛣 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Designer Electric permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked other any injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Otis Kelly Foster Dorothy Rush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4979 Linganore View Drive, Monrovia, MD 21770 Sharon J. Foster (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Olivet Cemetery 5/5/05 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fure a Service License ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Ent in the disease, or complications shock, or leart failure. List only one Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between rescleratic Cardiovasclar disease your Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an this certificete has autopsy performe 1 Yes or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 After atural ccident 5 Pending 1 Tyes 2 □No investigation after death completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD +/an istrar's Signature 31. Date filed (Monti 32. F State 2005 Registrar

				State	of Maryla		artment of rtificate o		Mental Hyg	giene () (	) 5	16648
			1. Decedent's Name (First, Middl	e, Last)					2. Date of Dee Month	th Dey	Yeer	3. Time of Death
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L	Funeral Director		5. Social Security Number 217–03–7778	6. Sex 1 ☐ M 2 1		86 Yrs.	Months Day	ar If Under 24 Hi s Hours Mi		, 1918		lace (State or Foreign try) yland
	P A H	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	ocation				1	Od. Inside City Limits
	ith with the Maryler 23s or 28s-f show	ত্	MD Worce	ster	Pc	comoke	City					1 ☐ Yes 2 🛣 No
	128 128 128	Director	10e. Street end Number	<u> </u>		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code		1	10g. Citizen of W	Vhet Coun	try?
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ana	should be filed vend Mental Hygle smarked other t	Be			Cr				e Disharo		θ)	
	mark mark	၉	Vernon Brooks I 19a. Informant's Name/Relations		Sr.	19b. Maili	na Address (Stre		Rurel Route Number		State. Zip	Code)
2	Trans	- 1	Vernon Baylis				-		ocomoke C			
ຍ໌ .	f Heal		20a. Method of Disposition		20b.	Place of Dispo	osition (Name of matory or other p		_	20c. Location -		
Ē	reges nent of t		1  Burial 2  □ Cremation 4  □ Donation 5  □ Other (S		om State		st Ceneter		5/5/2005 I	Pocomoke	e Cit	y, MD
	permit. Peges 1 and Department of Health Important: If them 27 any injury or other tr once.	Ì	21. Signature of Funeral Fervice	Licensee		- 2	2. Name and Add		uneral Ho			
٥	88 3 6 8	1	Muchael	AD	elim				Pocomoke			351
			23a. Pert1. Enter the disease, or shock, or heart failure. List	complications th	nat caused the dea	-					i i	Approximate therval Between
	hysician			C 1			0 0.	į.			ŀ	Doset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	· H	ypo (	Smo	Calit	4				5-days
ı		-	resoning in death)	6	Due to	or as a consec	quence of):	<i></i>		-	1	5-days
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5	tendir r use	Physician/M		d								
	the at	SICI	Part II. Other elgnificant condition	ns contributing t	o death but not re	sulting in the u	nderlying cause g	given in Part I.	23b. Did to	becco use con	tribute to	the cause of death?
	d by t								1 🗆 Y	es 2000	3 Prot	ably 4 Unknown
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	s cert direct	0	examiner? 1 Yes 2 No	Hospital:	☐ Inpatient 2□	ER/Outpatier	nt 3 DDA	Whor:	Home 5 ☐ Reside		ar (Specify	)
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	r daat	Ifica	3 Suicide 6 Could r	not be 28e, Pi	lece of Injury - At h	nome, farm, str	eet, factory, office	Ð	28f. Location (St	treet and Number	er or Rura	Route Number,
5 3	s afte	Cen	4   Homicide	bı	uilding, etc. (Speci	(ערוי			City or Town	1, SIBIB)		
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1,9	d, 3		30. Name end address of person of 1006- Make	who completed o	seuse of deeth (Ite	m 23a) (Type,	Print)	e, 1	MD 21	851		
	Stat Registra	C	31. Date filed (Month, Day, Year)  MAY 0 4	2005	St.,	ature &	and .					

Registrar DHMH 16 Rev 6/95

			For State Registrar	State	e of Marylan		artmen rtificate			and M		giene ( Reg. No.	05	16649
			1. Decedent's Name (First, Midd	le, Last)							2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		Roy Edward	Godlove							Month Mav	Day 4	2005	1:10 AM M
	Examin		4a. Facility Name (If not institution	n, give street and	d number)		4b. City,	Town, or	Location of	of Death	•	4c. Co	ounty of Deat	
			Homewood Nurs		,		Wi	llia	INSPO	rt		Wa	shingt	on-
	Funeral		5. Social Security Number	6. Sex 11☑ M 2□	7. Age (In yrs.	last birthday) 39 Yrs.	If Under Months	1 Year Days	Hours	Min.	8. Date of Birt (Month, Day	n	9. Birt	hplace (State or Foreign untry)
	Director		218-30-9496 Usual Residence of Decedent	21		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		J			Dec 2	0 191	5 Ma	ryland
	yland		10a. Slate 10b. County	/	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mar Ba-f st	tor	Maryland Wash	hington		Hage	rstow	m						1 ☐ Yes 2 No
	or 28	)ire	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of Whal Co	untry?
	23a	rai	906 Antietam	Dr				217	42			Unite	ed Sta	tes
	er de Items	une	11. Marital Status	Ame	Decedent Ever in U. d Forces?	.S. 13.	Was Deced If Yes, spec	lent of Hi dry Cuba	spanic Ori n, Mexicar	gin? (Spe ı, Puerto l	cify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	
36	rs aft	by Funeral Director	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1X1Y If Yes	es 2 □ No s, Give or Dates:		1 ☐ Yes 2	X No	Specify:			S	pecify: Wh	ite
9	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show the Madical Exambiar most by motified at	ed	15. Deceder	nt's Education		16a. Dece	dent's Usua	I Occupa	ition			16b. Kind	of Business/	Industry
215	hin 7.	pie	(Specify only higher Elementary/Secondary (0-12)	T .	ted) ge (1-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired,	luring mos )	t of workir	ng			•
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nd	tal Hy d oth	Be	17. Father's Name (First, Middle, James Clifto		170						(First, Middle,		rmame)	
<u> </u>	ould Men narke	To									nn Road			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Madical Examiliar must be restlined at once.		19a. Informant's Name/Relations Edna Price God								Route Numbe			
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ō	lospital or Attending Physic hours after death: uneral Director: After this sly filled in by the funeral director.	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pendii investi del Could determ	not be nined 28e. P	lace of Injury - At ho uilding, etc. (Specify	Injury ome, farm, str	M eet, factory	8c. Injury Work 1   Y	at ? fes 2 1	No 2	8d. Describe h  8f. Location (S  City or Tow	Street and Mm, State)	ccurred	ral Route Number,
ō	the Hospital or Attending Physinin 24 hours after death. Ithe Funeral Director: After this mpletely filled in by the funeral di	edical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  5 Pendii investi 6 Could determ	gation not be hined 28e. P b ng Physicien: To Exemination	lace of Injury - At ho uilding, etc. (Specify	Injury ome, farm, str	M eet, factory	Bc. Injury Work 1  Y  , office  at the tim in my op	at ? Yes 2 1	No 2	8d. Describe h  8f. Location (S  City or Tow  nd due to the o  d at the time, o	Street and A m, State) cause(s) and	ccurred  lumber or Ru  d manner as ace, and due	ral Route Number, stated. to the cause(s)
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ō	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	edical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	gation not be along the prince of the prince	lace of Injury - At ho uilding, etc. (Specifi the best of my kno he basis of examina namer stated.	Injury  Dime, farm, str  y)  Iwledge, death tion and/or in	M eet, factory n occurred a vestigation.	Bc. Injury Work 1  Y  , office  at the tim in my op	at ? Yes 2 1	No 2	8d. Describe h  8f. Location (S  City or Tow  nd due to the o  d at the time, o	Street and A m, State) cause(s) and	ccurred  lumber or Ru  d manner as ace, and due	ral Route Number, stated. to the cause(s)
Division of	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier 30. Name and address person	gation not be 28e. P b	lace of Injury - At ho uilding, etc. (Specify the best of my kno he basis of examina	Injury  Dime, farm, str  y)  Iwledge, death tion and/or in	M eet, factory n occurred a vestigation.	Bc. Injury Work 1  Y  , office  at the tim in my op	at ? Yes 2 1	No 2	8d. Describe h  8f. Location (S  City or Tow  nd due to the o  d at the time, o	Street and A m, State) cause(s) and	ccurred  lumber or Ru  d manner as ace, and due	ral Route Number, stated. to the cause(s)
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			1 = For State Registrar	State o	f Marylar		artment rtificate				lental Hy	giene ()	05	6650
	Dhamia		1. Decedent's Name (First, Middl	e, Last)							2. Date of De.	ath Day	Year	3. Time of Death
	Physic /Medi		Michael	Harris		Griff	in				May 1,	2005		5:28 <sup>p м</sup>
	Exami		4a. Facility Name (If not institution	-	,		4b. City, T	Town, or	Location of	of Death		4c. Cou	nty of Death	
			18505 Queen E	Clizabeth	Drive			Olne	У			Мо	ntgome	ery
	Funeral		5. Social Security Number	6. Sex 1X M 2 ☐ F	7. Age (In yrs.		If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birl (Month, Da	h v. Year)	9. Birth	olace (State or Foreign ntry)
	Director		213-56-1792	ACIM 20 F	53	Yrs.					Dec. 13			land
	and *		Usual Residence of Decedent  10a. State  10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Aarylan Fahow ed al	5												1 ☐ Yes 2 🗷 No
	1he N	Director	Maryland Mont  10e. Street and Number	gomery		01ney		Cada				10 07		
	with		18505 Queen	Elizabeth	Drive		10f. Zip		832			10g. Citizen		ntry?
	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28e-f ahow the Medical Examer must be notified at	Funerai	11. Marital Status		edent Ever in U	1 5 12 1	Was Docode			igin 2 /Cn	coif. Van as Na	US.	A. ace - Ameri	oon Indian
	lter d	Ē	1 ☐ Never Married 2 ☐ Married	Armed Fo	rces?	13.	If Yes, speci	fy Cubar	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	14. F	lack, White,	
39	Irs af	Þ	3 Widowed 4 Divorced	If Yes Giv	/B		1 ☐ Yes 2	<b>X</b> No	Specify:			Spe	city: Wh	nite
21215-0036	2 hou	Completed	15. Deceden	t's Education		16a. Dece	dent's Usual	l Occupa	tion			16b. Kind of	Business/In	dustry
215	hin 7	pie	(Specify only highe. Elementary/Secondary (0-12)	st grade completed) College (1	-4or 5+)	(Give	kind of worl DO NOT use	k done d e retired)	uring mos	t of work	ing			,
21,	d with	E O	cionionally/obcoridary (o 12)	5+	-40( 5+)	Tea	cher					Techno	ology	Education
פ	othe othe vant,	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	e (First, Middle,	Maiden Sum	ame)	
<u>a</u>	Aente Aente rkad rlc e	To	George Griffi	n					Syl	oil 1	Brown			
Maryland	s me	ľ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rur	al Route Numbe	or, City or Tox	m, State, Zip	Code)
Σ	and 2 valith n 27 I		Sheryl Martin	Griffin/ N	Wife	1850	5 Que	en E	lizak	oeth	Drive,	Olney,	, MD 2	0832
<u>Sre</u>	of He	1 3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	0. 🗆 🖰 🖰		Place of Dispo	sition (Nam	e of		May	Date	20c. Locatio		
Ĕ	Page His Fago	١.,	1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		State	etropoli	-			2005	1	Alevano	Tria	Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-1 ahov any injury or other traumatic event, it is Medical Exp. is actival be notified at any injury or other traumatic event, it is Medical Exp. is actival be notified at any once.		21. Signature of Funeral Service	Lio hsee	9	22	Name and	L Addres	s of Facilit		Funera:			VIIGIIII
m	89 1 2 8	10 10	Muan	July	erc	5	00 Un	iver	sity	Blvc	d, W, S:	ilver	Spring	, MD 20901
			23a. Part. Enter the disease, or shock, or heart failure. List	complications that c	aused the deat	th. Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician	ε.	Immediate Cause (Final disease or condition		Cancer									Onset and Death 2 Years
	/Medical		resulting in death)	a Due to (	or as a conseq	quence of):								Z Tears
	Examiner		Conversion that the same distance	b										
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a conseq	juence of):								
	nd nd trans	Examine	cause. Enter Underlying that initiated events	с										
ó	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (	or as a conseq	luence of):								
8760,	ate he	dicai		d										
9		Mec	IF FEMALE:											_
Вох	death certific e attending p od for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	ıl death 3 □	Ectopic pre	gnancy					Date of delive Month	
	0 0 2	sic	1 Yes 2 No	4□Pregn 9□Unkno	ant at time of down	leath 5□	] Other <i>(spe</i>	cify)					MOHIT	Day Year
<u>Ч</u>	that the	Phy			and to a second	100					00 011			
Ś	res the	by	Part II. Other significant condition	ons contributing to de	ath but not res	uiting in the ui	noerlying ca	use give	n in Part i.			ibacco use co ′es 2∐No		ne cause of death?
oro	v requir been s should	ted									1 1	es 2 No	3   Proc	ably 4 Unknown
Vital Record	2 S S	Completed									24a. Was autop	sv	prior to cor	psy findings available mpletion of cause of
		S									perfoi 1 ☐ Yes	med? 2 □ No	death?	2 □ No
/ita	Physiclen: this certific ral director,	Be	25. Was case referred to medical examiner?					-,			Check only o			
of \	Physi this c al dire	2	1 ☐ Yes 2 🕌 No			ER/Outpatien	t 3 DOA	Othe	r. 4□Nu	rsing Ho	me 5 🖰 Resid	ence 6 🗆 C	ther (Specif	y)
	De te	Certification:	27. Manner of Death  1 Anatural 5 ☐ Pendin	28a. Date of (Mont)	of Injury h, Day Year)	28b. Time of Injury		lc. Injury Work	?		28d. Describe h	ow injury occ	urred	
Division	ol or Attending is after death. I Diractor: After d in by the fune	cati	2 Accident investig	not be			М		es 2 🗆 l	-				
Ν	or At fter d piracl	ıţ	4 Homicide determ	ined 289. Place	of Injury - At ho ng, etc. <i>(Specif</i> )	ome, farm, stri 'y)	eet, factory,	office			28f. Location (S City or Tow	treet and Nui n, State)	nber or Rura	I Route Number,
	e Hospitel or 24 hours afte e Funeral Dire letely filled in t		-0.0.17											
	Hosp 14 ho Fune Fune tely f	edical	(Check only 2 Madical	g Physician: To the Examiner: On the ba	isis of examina	owledge, death ition and/or inv	n occurred at restigation, i	t the time in my opi	e, date and inion, deat	d place, a th occurr	and due to the o ed at the time, o	ause(s) and a date and place	manner as si e, and due to	tated. the cause(s)
	훈 늘 문 문	Med	one)  29b. Signature and title of Certifier	and mann	er stated.									
	or To no	-	Do Pll	1/1	_	_		License				29d. Date sigr	6	
,	10		y 0,70=1,000					72	014			177 2	/200	<b>'&gt;</b>
			30. Name and address of person ISABCUA MART	who completed caus	of death (Item	n 23a) (Type,	Print)	h10	4	10 2	0707			
			31. Date filed (Month, Day, Year)	20.4	anistrar's Siana	ture :	~ ~	700	1	-	- ( - (			
	Sta Registr		MAY 0 3	2.005	e of death (Item 343 Cd egistrar's Signa	& Ap	and I							

		Decedent's Nam	e (First, Middle, L	ast)		- 0	ertificate	011	Dealli	2. Date of De	Reg. No. eeth Day	Year	3. Time of Dea
ysicia Aedica	al -	Elizabeth			or)	-			4b. City, Town, or L	04/23/	2005	ty of Death	2:05 PM
amine		Manor Car			·				Chevy Cha			tgomer	У
eral		5. Social Security N		Sex 7.	Age (In yrs.	last birthda	/) If Under		If Under 24 Hrs. Hours Min.	8. Date of Bir	th av Year)	9. Birthpla	ace (State or For
ctor		232-76-00 Usual Residence of	f Decedent	1□M 21XF	99	Yrs.			riours iviiri.	05/07,	71905	Washi	ngton D
100	٦	10a. State	10b. County	oru		y, Town or I 7y Cha						10	od. Inside City Lir 1 X Yes 2 □
dig.	Director	MD 10e. Street end Nur	Montgom	егу	Ollev	y Olla	10f. Zip	20do			10g. Citizen of	14/h at Oa and	
2	<u></u>		nes Mill	Road				815			rog. Onizeri or	USA	·y:
E E	Funeral	11. Marital Status		12. Was Decede	ent Ever in U,	S. 13			ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	)- 14. Ra	ice - America	
3	و ک	1 ☐ Never Marri 3 ☐ Widowed	ied 2□ Married 4□Divorced	Armed Force 1 ☐ Yes X If Yes, Give Year or Date			1 ☐ Yes 2		Specify:	Hican, etc.)		ack, White, e ify: Whit	
Wedical	Completed	(Spec	15. Decedent's E	ducation ade completed)	or 5±)	16a. Dec (Giv life.	edent's Usual e kind of work DO NOT use	Occup done o retired	ation during most of work d)	ing	16b. Kind of I	Business/Ind	ustry
2	ပ္ပ	12			,	Hon	nemaker					n Home	
even	Be	17. Father's Name	(First, Middle, Les	t)					18. Mother's Nam	,		me)	
matic	P	Maurice				104 14-	lina Add	/C+		Mary V		Circle 7	Codel
treur		19a. Informant's Na		(Type, Print) / Daught	or				and Number or Run				Joae)
other	ŀ	20a. Method of Disp		/ Daugne			oosition (Nam ematory or oti		Rd., Beth	Date P	20c. Location		vn, State
50			☐ Cremation 3 ( 5 ☐ Other (Spec	Removal from Sta	ile		<sub>ematory or oti</sub> Heave <b>n</b>	ner piad	I I	5/02/05	Cilwo	r Spri	ing, MD
	-	21. Signature of Fa			Gali	1	22. Name and		ss of Facility		DIIVE	r spr.	ing, m
£ 8	-	Van	Kin	- MO	1378				vlers Son nsin Ave.		achinat	on DC	20016
ian ical ner		shock, or hear Immediate Cause ( disease or condition resulting in death)	(Final	plications that cause on each	hmia		equence of):	or dylli	g, such as cardiao	or respiratory a	11031,	1	Approximate Interval Betweer Onset and Deat
Sit.	ine.			b									
	il Examiner	Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or	inditions, nmediate erlying injury		Due to (cr	ras a cons	equence of).						
s :	Medical	that initiated events resulting in death) L		d	Due to (or	as a conse	equence of):					1	
i or u	cian								<u></u>	7			
detached	/ Physi	Part II. Other signifi Advanc	ed Demen		n but not resu	ulting in the	underlying ca	use giv	en in Part I.		tobacco use co Yes 2□ No		the cause of de ably 4. Unk
should be detached for use as the	Completed by Physician/M	<b>5</b>								24a. Was perfo	an autopsy ormed?	avai	e autopsy findin lable prior to pletion of cause eath?
age	Ē									10	Yes 2 No		Yes 2 No
ctor, p		25. Was case referr	red to medical						26. Place of Death	h (Check only d	one)		
Inerai dire	P 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☑ Nursi							4 Mursing Ho		dence 6 □Ot how injury occu			
completely filled in by the funeral difector, page 2	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide determined determined building, efc. (Specify)  M 1 ☐ Ye  28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)							Yes 2□No	28f. Location (: City or Tox	Street and Num vn. State)	ber or Rural	Route Number,
letely filled		29a. Certifier (Check only one)	12 Certifying Pl 2 ☐ Medical Exa	nysician: To the beaminer: On the basis and manner	of examinat	wledge, dea ion and/or i	th occurred a nvestigation, i	the tim	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and m date and place	anner as sta , and due to t	ted. he cause(s)
id Ho:	Σ	29b. Signature and	title of certifier	and manner			29c.	License	e number		29d. Date sign	ed (Month, D	ay, Yeer)
			19				0	00	54566	,	4126,	105	

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of	Marylar	-	artment of H tificate of I	lealth and N Death		iene	5 1	6652
	Physici	an	Decedent's Name (First, Middle, Last)  Portho  Coll  Co					_	2. Date of Dear Month April	_	Year 05	3. Time of Death 6:45 A M
	/Medio Examir		Bertha Gib  4a. Facility Name (If not institution, give s	SON reet and num	ber)		4b. City, Town, or	Location of Death	APLII	4c. County of		THE TANK
			Manor Care				Chevy	Chase		Montg	omery	
	Funeral Director		370-22-0022	M 2 <b>∑</b> F	7. Age (In yrs. 99	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) June 29	, 1905	9. Birthpla Countr Sout	ace (State or Foreign th Carolina
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation	<u> </u>			100	d. Inside City Limits
	Mary a-f sh	tor	D.C. N/A		Wa	shingt	on					Y Yes 2 No
	ith the	Olrec	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	hat Countr	y?
	eth w	ral	1332 Montague St				20011		1	United		
5-0036	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural; or itame 23a or 28e-f show any injury or other treumatic event, the Madical Examinar must be notified at ADRE.	by Funeral Director	11. Marital Status 1  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Deced Armed For 1 Tes If Yes, Give Year or Da	2X No		Was Decedent of Hi fYes, specify Cuba I□Yes 21□No	ispanic Origin? ( <i>S</i> p in, Mexican, Puerto <i>Specify:</i>	ecify Yes or No- Rican, etc.)	Black	American K, White, et Blac	tc.
2	72 ho naturi	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	lent's Usual Occupa	ation during most of work	ina	16b. Kind of Bus	siness/Indu	istry
2121	within ene. than	Junc	Elementary/Secondary (0-12)	College (1-	4or 5+)		<i>DO NOT</i> use <i>retired</i> tical Nur			Priva	te Ho	mo.
<u>5</u>	Hygi other	Be C	17. Father's Name (First, Middle, Last)			1140	TEGI NGI	18. Mother's Name	e (First, Middle, I			ille
Maryland	Menta Menta arked	To B	Lewis Robinson					Martha 2	Zemp			
Jar	and rem		19a. Informant's Name/Relationship (Typ					and Number or Run				
e,	1 end Healti am 27		Arline G. Gibbs /	Daugh						ashingt 20c. Location - (		.C. 20011
altimore,	Peges ent of ry or of		1 X Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from S			sition (Name of natory or other plac Memorial	4/28		Suitlan		
Balti	permit. Depertm Imports any inju		21. Signature of Funeral Service License	elsbe	vril.			ss of FacilityMcGt	ire Fun	eral Se	rvice	
			23a. Patr. Enter the disease, or complic shock, or heart failure. List only on	ations that ca	used the deal						-	Approximate
B	nysician		Immediate Cause (Final disease or condition	Cause on ea		NIGES	TIVE	HEART	FAI	LURE		nterval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a consec	quence of):		HEART RIERY	× .			
		er	Sequentially list conditions b. if any, leading to immediate	Due to (c	c consecutive as a consecutive	quence of):	ARY A	RIENY	013	EASE		
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
60,	icate be executed physician and s the burial-transit	e Ex	resulting in death) Last	Due to (d	r as a consec	quence of):						
68760,		edical	d.									
P.O. Box (	The law requires thet the death certific its has been signed by the attending p rage 2 should be detached for use as!	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live bir	ome of pregnath 2 ☐ Feta nt at time of c	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th D	/ Day Year
	res thet igned by be deta	by Ph	Part II. Other significant conditions cont	ibuting to dea	ath but not res	sulting in the un	iderlying cause give	en in Part I.	23e. Did tob	acco use contri	bute to the	cause of death?
ord	w require been sig should t								1 □ Ye	s 21100 3	3 ☐ Probab	oly 4 □Unknown
Vital Records,		Completed							24a. Was at autops perform	y pr ned? de	or to comp	sy findings available pletion of cause of
	s certif	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Ho	spital:	Q.	Ispo	Othe	26. Place of Deati				
Of	Attending Physician: or death. ector: After this certifici by the funeral director,	-	27. Manner of Death	28a. Date of	Injury	28b. Time of	28c. Injury	at	me 5 Reside			
Sior	ending eath. or: After he funer	atlo	1 Natural 5 Pending 2 Accident investigation	{MONIN	, Day Year)	Injury	M 1 🗆 \	r? res 2 □No				
Division	tal or Att s efter d al Direct ad in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	of Injury - At h g, etc. <i>(Specil</i>	ome, farm, stre	eet, factory, office		28f. Location (St. City or Town	reet and Numbe , State)	r or Rural F	Route Number,
	To the Hospital or Attendin within 24 hours effer death. To the Funerel Director: Att completely filled in by the fun	edical	29a. Certifier Character (Character one) Control one) Certifying Physical Examination (Character of the Certifying Physical Caracter of the Certifier one)	cian: To the base. On the base and manner	sis of examina	owledge, death	occurred at the tim estigation, in my op	e, date and place, pinion, death occurr	and due to the ca ed at the time, da	iuse(s) and man ate and place, ar	ner as stated	ed. ne cause(s)
	To the within To the comp	Ĭ.	29b. Signature and title of certifier				29c. License	number	29	d. Date signed		•
	3			-		and,		55712	4	4/2	710	25
	3		30. Name and address of person who com Trong Bao, M.D.	1321	9 Exec	utive H		ace, Germ	antown,	MD 208	374	
	Sta Registri	- 2	31. Date filed (Month, Day, Year) MAY 0 3 200	32911e	gistrar's Signa	ature.	Me.					

		1	For State Registrar	State of M	aryland /		artment of H		nd Mei		iene	05	166	53
9	- April		Decedent's Name (First, Middle, Last	")					2.	Date of Deat	h	Vana	3. Time of	Death
	Physicia		Herbert Ellswort	h Garret	t. Sr.				AT	Month oril	26	2005	4:35	P M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of	f Death		4c. Co	ounty of Death		
	_xam.	Ĭ.	Prince George's H	ospital			Chever1	У			Pri	nce Ge	orge's	
	Funeral		5. Social Security Number 6. Se	7. A	ge (In yrs. last b	-	If Under 1 Year Months Days	If Under 2 Hours	Min	Date of Birth (Month, Day,	Year)	Cou	place (State of	
	Director		3/9-03-//43	M 2□F	89	Yrs.			N	lov. 29	, 191	5 Newpo	rt News	, VA
	pur *	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside Cit	ty Limits
	sho	ō		1 -		_						+	1X Yes	2 🗌 No
	28a-1	Director	MD Prince G	eorge s	Cheve	тту	10f, Zip Code			1	0g. Citize	n of What Cou	ntry?	
	with Baor		3034 Crest Avenue				20785					USA		
	ns 23	era	11. Marital Status	12. Was Decedent		13.	Was Decedent of H	ispanic Orig	jin? (Specif	y Yes or No-	14	. Race - Ameri		
10	riter o	Funeral	1 Never Married 2 Married	Armed Forces' 1 ☐ Yes 2 X			f Yes, specify Cuba		, Puerto Rio	an, etc.)		Black, White,	etc.	
036	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2X No	Specify:			5	pecify: Whi	te	
2-0	within 72 hours after death with the Maryland ene. Then "neturel", or items 23a or 28a-1 show ha Medical Evanian remost be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16	(Give	dent's Usual Occup	during most	of working		16b. Kind	of Business/Ir	dustry	
2	thin le.	nple	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retired	1)			T	al Dist	ad base or	
21	be filed within 72 hours after death with the Marylan hall Hygiene. Ind althygiene and a state of show of a chert then "neturel; or liems 23a or 28a-1 show event. The Medical Evanture must be notified at		10			Sale	es	19 Mother	r's Name /F	First, Middle, I			LIDULO	<u>.                                    </u>
ğ	be fill	Be	17. Father's Name (First, Middle, Last)									arriarre)		
Maryland 21215-0036	s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic eve	L <sub>O</sub>	George Pinkethman 19a. Informant's Name/Relationship (7		1 10	9h Mailir	ng Address (Street			Marsha Route Number		Town. State. Zi	Code)	
Ma	od 2 sho lth and 27 is ma		Jeffrey E. Garret		illa		Pamela Ro							
	s 1 and 2 if Health item 27 I	1	20a. Method of Disposition	t II, BC			esition (Name of matory or other place		Date			ation - City or T		
2	Pages nent of I unt: If ite		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		9		National (		05/14	/05	S111+	land, M	arvlan	d
Baltimore,	그 튼튼증 .		21. Signature of Funeral Service Licen		wasim.		2. Name and Addre							<u> </u>
Ba	permi Depa Impo any ii		12 Constan	200	asch		4739 Balt							nd
			23a. Part1. Enter the disease, or comp	olications that cause	ed the death. De	_							Approximate Interval Bet	Θ
	Physician		shock, or heart failure. List only of Immediate Cause (Final		atory E	7011.	1200						Onset and I	Death
	/Medical		disease or condition resulting in death)		s a consequenc		ire						2 Day	
	Examiner		Sequentially list conditions	b. Bilate	ral Pnu	ıemoı	nia						13 Da	ys
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequenc	ce of):								
	nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
,092	ite be executed iysician and he burial-transit		lesuring in Obalin Last	Due to (or a	s a consequenc	ce or):								
687	F > 6	dical		d										
9 ×	ding	/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy						23	d. Date of deli	rerv	
Вох	death certificat e attending phy d for use as th	ian	in the past 12 months?	1 Live birth	2 ☐ Fetal dea at time of death	ath 3	□Ectopic pregnancy □ Other (specify)	У				Month		Year
o.	0 0 0	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown										
0	that the	by Pt	Part II. Other significant conditions o	ontributing to death	but not resulting	g in the ι	inderlying cause giv	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of c	death?
rds	equires en signe ould be	d b	Alzhiemers Deme	ntia						1 □ Y	es 2 🗆	No 3□ Pro	bably 4 🔀 l	Unknown
Records,	s been s should	olete								24a. Was a		24b. Were au	opsy findings ompletion of c	available
Re	ysicien: The law requires that the is certificate has been signed by the director, page 2 should be detached.	Completed								perfor	med? 2X No	death? 1 🗆 Yes		
Vital		BeC	25. Was case referred to medical					26. Place	of Death (	Check only o	10)			
<b>†</b> \	Physicien: this certific al director,	5	examiner? 1 ☐ Yes 2 X No	Hospital: 1X Inpa	tient 2 ER/	Outpatie	III JUDON					☐Other (Spec	ify)	
n of			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28t Day Year)	b. Time o	Wor			d. Describe h	ow injury	occurred		
Sio	Attending r death.	catl	2 Accident investigation 3 Suicide 6 Could not be					Yes 2		f Lagation (C	'tract and	Number or Ru	ral Pauta Num	abor
Division	or At offer of Direct in by	Certification:	4 Homicide determined	289. Place of 1	njury - At nome, etc. <i>(Specify)</i>	, tarm, st	reet, factory, office		20	City or Tow		TVBITIDOT OF TIE	ar riodic right	1001,
	Hospitel 4 hours a Funerel [ tely filled	Ö	29a. Certifier 1X Certifying Ph	ysician: To the bes	st of my knowled	doe dea	th occurred at the ti	me, date an	nd place, an	d due to the o	ause(s) a	and manner as	stated.	
	24 hos Fun etely	edical	(Check only 2 Medical Examone)	niner: On the basis and manner:	of examination	and/or in	nvestigation, in my	opinion, dea	th occurred	at the time, o	date and	place, and due	to the cause(s	s)
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier	un	wy	1	29c. Licens	se number	73	1410	29d. Date	signed (Month	Day, Year)	
0	1		30. Name and address of person who	completed cause of	death I em 23	a) (Type	, Print)	-						
1	- (4)	1	Revathy Murthy,	6130 Lan				, Mar	yland	2078	5			
	St: Regist	ate	31. Date filed (Month, Day, Year)	A. Regis	strar's Signature									
	negisi	i ai	MAY 0 3 ZUU	- JAMES	1 1	Marie								

ioio	_	1. Decedent's Name (First, Min								2. Date of D Month	D	ay Year	3. Time of Death
icia dica	al .	Milford								May	10	2005 c. County of Death	1:25 A M
nine	er .	4a. Facility Name (If not institu VA Maryland He	-					y Poin	tion of Death			Cecil	1
al or		5. Social Security Number 102–12–5765	6. Sex	M 2□F	7. Age (In yrs. 84	last birthday) Yrs.	If Under Months		Inder 24 Hrs. ours Min.	8. Date of Bi (Month, D Aug.	irth lay, Yea, 6,	9. Birth Cot New	nplace (State or Foreign into) York
		Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	ţo	Maryland Har	rford			Aberde	en		_				XXYes 2 □ No
	al Director	10e. Street and Number 334 Edmund St	treet				10f. Zip	21001			1	Citizen of What Co	
	by Funeral	11. Marital Status  1 Never Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married Nover Married Nover Married Nover Married Nover Married Nover Nover Married Nover Nove	Married	Armed For			Was Deced If Yes, spec 1  Yes		oic Origin? (Specifican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White Specify: Wh:	e, etc.
	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1		cation completed) College (1-	-4or 5+)	(Give	kind of wor DO NOT us	se retired)	g most of work	ng	16b.	Kind of Business/I	
1	S	8 17. Father's Name (First, Midd	lle (ast)	0		<u> </u>	abore		Mother's Name	(First, Middl	e, Maide		<u> </u>
	To Be	Leon E. Grav								e Phel			
1	-	19a. Informant's Name/Relati	onship (Typ	oe, Print)			-					or Town, State, Z	lip Code)
		Carol A. Troy	(daug	ghter)	20h	_			Aberde	en, MD		01 Location - City or	Town State
		20a. Method of Disposition  1  Burial  Commandation		emoval from S		Place of Dispo cemetery, crei						t Cheste	
		*4 □Donation 5 □Othe  21. Signature of Funeral Serv		98	K•F				5°Funer	Charles and the Control of the Contr			- / - LA
		> Kersknf	nup	Ungl	espe	A	berde	en, Ma	ryland	21001-	339	9	
n		23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	, or compli- List only on a	e cause on ea	aused the dea ach line. on Canc		ter the mod	le of dying, su	ch as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death Unknown
al er		resulting in death)		Due to (	or as a conse	quence of):							
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1		or as a conse	quence of):							
		that initiated events resulting in death) Last		Due to (	or as a conse	quence of):							
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	2	1 Live b	come of pregrinth 2 Fet	al death 3	□Ectopic pi □ Other (sp					23d. Date of deli Month	very Day Year
	Phys	9 ☐ Unknown  Part II. Other significant con	ditions cor			culting in the s	inderhing o	eause awen in	Part I	23e Dio	i tobacc	o use contribute to	the cause of death?
	þ	rait ii. Other significant con	unions cor	ithouting to de	satir but not re	Sulling at the t	andonying c	adoc giveiriii					obably 4 XUnknown
	Completed										opsy fo <u>rmed?</u>	prior to death?	itopsy findings available completion of cause of 2 \square\text{No}
	BeC	25. Was case referred to med examiner?	-						Place of Deat	h (Check only			
	은	1 ☐ Yes 2 XNo	11			ER/Outpatie			Nursing Ho			6 □Other (Specially occurred	cify)
completely filled in by the funeral director, page Medical Certification; To Be Com		27. Manner of Death  1 Activate  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Yes 2 No  28d. Describe how injury occurred Work?  1 Yes 2 No  28d. Describe how injury occurred Work?  1 Yes 2 No  28d. Describe how injury occurred Work?  28d. Describe how injury occurred Work?  28d. Describe how injury occurred Work?  28d. Describe how injury occurred Work?  28d. Describe how injury occurred Work?  28d. Describe how injury occurred Work?  28d. Describe how injury occurred							and Number or Ru	ural Route Number,			
	Certi	4 Homicide building, etc. (Specify)  City or Town, State)											
	Medical (										to the cause(s)		
	Σ	29b. Signature and title of ce	rtifier		1			c. License nu				Date signed (Mont.	h, Day, Year)
		J.	ranc	11 2	nang.	M.D		010105	80281		5,	/10/05	
		30. Name and address of per		Lateral		m 02-1 /	Dei						

			1- For State of Maryland / Department of Heat Certificate of De			iene og. No. 005	16655
			Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
	Physici /Medi		Elwood Cletus Housden		Month May	Day Year 3 2005	
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo	ocation of Death		4c. County of Dea	
			Frederick Memorial Hospital Frederic	ck		Frederi	ck
	Funeral			Hours Min.	8. Date of Birth (Month, Day, Nov. 20	Year) 9. Bii	rthplace (State or Foreign
	Director		230-68-2697 X W 201 60 Yrs.		Nov. 20	,1944 Wes	st Virginia
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	f she	ō	W Jefferson Ranson				14 Yes 2 No
	18e 1	Director	10e. Street and Number		10	0g. Citizen of What C	Ountry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28e-f show ont, it is Madical Exa ultrativast be multised at		19 Wood Lawn Court 19 10f. Zin Code 25438			United S	
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispa	anic Origin? (Spec	cify Yes or No-	14. Race - Am	erican Indian.
G	r te	Fur	Armed Forces? If Yes, specify Cuban, N 1 □ Never Married 2€ Married 1 □ Yes 2 ₹ No		lican, etc.)	Black, Whi	ite, etc.
ğ	alt, o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2XXNo S	Specify:		Specify: V	√hite
5-0	d within 72 hours after dea giene. r than "natural; or items it a Medical Exp. ultret is	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during the completed)	on		16b. Kind of Business	s/Industry
21	within lene. than	nple	Elementary/Secondary (0-12) College (1-4or 5+)		9		
2	filed within Hygiene. other than rent, It's M		12 Maintenance Dep				ard Company
Maryland 21215-0036	ad lata	Be	17. Father's Name (First, Middle, Last) Rufus M. Housden	8. Mother's Name	First, Middle, N, Sibole	Maiden Sumame)	
3	should be and Mental s marked o umatic sve	1º					
Mai	d 2 sho h and I 7 Is ma trauma		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Christine J. Housden/Wife  19b. Mailing Address ( <i>Street and</i> 19 Woodlawn Cou	ourt. Ran	Route Number, SOD. WV	City or Town, State, 25438	Zip Code)
	ges 1 and 2 should to f Health and Mer if item 27 is marke or other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of	Da Da		20c. Location - City or	Town State
Baltimore,	permit. Pages Department of I Importent: If ite any njury or of		1 GBurial 2 Cremation 3 Removal from State Roseda le (Profile V)	May 6	_	Martinsbur	
臣	it. Partmer intent injury		4 Donation 5 Other (Specify)	15.00			
Ba	permit. Pag Department Importent: I any njury o		Melvin T. S	Strider	Co.,Inc		
			23a. Parl 1. Enfer the disease. At complications that caused the death. Do not enter the mode of dying, stack, or heart failure. Use only one cause on each line.	,Charles	Town, W	V 25414	
			sbock, or heart failure. List only one cause on each line.	such as cardiac or	respiratory arre	nst,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Longe, Vascular Kyling in death)	it Ken	al Cell	Careino	Ma
Ш	Examiner		Bue to (or as a consequence of):	10 -		0 ( 4	
		0	Sequentially list conditions, if any, leading to immediate  b. Dueto(or as a consequence of):	vasent	arcoc	igula patt	109
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	Fai	. 0	,	1
	af-tra	xai	that initiated events resulting in death) Last C. Due to (or as a consequence of):	1 000	Tuch	<u> </u>	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical					
687	ficate g phy s the	edlo	g				
Вох	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	slivery
Ď	death atte	cla	in the past 12 months?  1 \( \text{Live birth} \) 2 \( \text{Fetal death} \) 3 \( \text{Ectopic pregnancy} \)  1 \( \text{Yes} \) 2 \( \text{No} \)  4 \( \text{Pregnant at time of death} \) 5 \( \text{Other (specify)} \)			Month	Day Year
0	the y th iche	hys	9 ☐ Unknown				
٣,	requires that een signed b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
rds	quire on sig uld b				1 ☐ Ye	s 2 No 3 P	robably 4 dunknown
Records,	> 0 0	Completed			24a. Was an		utopsy findings available
æ	0 -C 0	mo U			autopsy	prior to death?	completion of cause of
		a	25. Was case referred to medical 26	6. Place of Death (			s 2 No
>	5 S S	To B	examiner?			nce 6 Other (Spe	acify)
	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at			w injury occurred	
Division	Attending r death. ector: After by the fune	Certification;	2 Accident investigation M 1 Yes	s 2 🗆 No			
Νį	r Atte	tif	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	3f. Location (Str. City or Town,	eet and Number or R	ural Route Number,
	tel o	Cer	3.55(5,557)		- in y - in , in , in , in , in , in , in , in	, class,	
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier (Check only and)  (Check only and)  (Check only and)  (Check only and)  (Check only and)  (Check only and)  (Check only and)  (Check only and)  (Check only and)  (Check only and)  (Check only and)  (Check only and)  (Check only and)  (Check only and)	date and place, an	nd due to the car	use(s) and manner a	s stated.
	To the h within 2 To the F complete	Medical	and manner stated.				
ı	70 Vill	~	29b. Signature and Illie of cynifier 29c. License nu	umber	29	d. Date signed (Moni	th, Day, Year)
			1 Camadam ND D-	1001	,	3/2/20	res
	11 0		30, Name and address of person who complete cause of death (Item 23a) (Tyge, Print)  MCHAMMED M. MCHIUDDICY, MD 80	1 7011	House	15 A 1	DOM-
9	4-8		31. Date filed (Month only Yun) 6 2005 32. Begistrar's Signature	· · · · · · ·	11000	se me,	r CHERICK M
	Sta Registr	_	31. Date filed (Month 12) Yur 6 2005 32. Registrar's Signature				
	3.0.		and the second				

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State of M

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16656
e.

**Physician** /Medical Examiner

**Funeral** Director

Directo Be

permit. Pages 1 and 2 should be filad within 72 hours after death with the Maryland Department of Haalth and Mantal Hygiana. Important: if item 27 is marked other then "netural", or items 23s or 28s-1 show ling or other traumatic event; if a Medical Examera must be notified at 2008.

**Physician** 

/Medical

Baltimore, Maryland 21215-0020

Examiner If Hospital or Attanding Physician: The law raquiras mat ma use users commons or 124 hours after death.

• Funeral Director: After this certificate has been signed by the attending physician and slately filled in by the funeral director, page 2 should be datached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

To the 12 State

31. Date filed (Month, Day, Year)

MAY 03 2005

Registrar's Signature

1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Yeer Muriel Grace Fitzgerald Huttmann April 28, 2005 12:10PM 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Springhouse at Westwood Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Months 1 □ M 2 🗓 F 83 Yrs. 050-18-4433 Feb.10,1922 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1⊠Yes 2□No Md. Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5015 Worthington Drive 20816 Funerai U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: ۾ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas F. Fitzgerald Marcella Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5015 Worthington Dr. Bethesda, Md. 20816 Charles F. Huttmann/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mav 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2005 Silver Spring, Md. 21. Signature of Fune al Service Lice see 22. Name and Address of Facility DeVol Funeral Home 2222 Wisc. Ave., N.W. Washington, D.C.20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia 2 Weeks Due to (or as a consequence of): Examine Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Late effects of Cerebral Vascular Accident Physician/Medical Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Aphasia, Osteoarthritis à Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 11 1 Yes 2 X No. 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) SSISTED 1 Yes 2X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier (Check only one) 12 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 29, 2005 D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6844 Tulip Hill Terrace Susan J. Miller, M.D. Bethesda, Maryland 20816

Registrar

			For State Registrar	State of Ma	-		rtment of H			giene Reg. No.	05	16657
			Decedent's Name (First, Middle,	Last)					2. Date of De	ath		3. Time of Death
	Physicia /Medic		Angela Ca	therine	Huch				April 2	8, <sup>Day</sup>	05 Yea	9:00 Р м
	Examin		4a. Facility Name (If not institution, g	rive street and number)			4b. City, Town, or	Location of Death		4c. C	ounty of De	eath
			15004 Layhill R	.oad			Silver S					gomery
	Funeral			. Sex 7. Age 1  M 2  F	(In yrs. last birt		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Yea <i>r)</i>		Birthplace (State or Foreign Country)
	Director		578-30-2175 Usual Residence of Decedent	TEM EQ.	94	Yrs.			May 24	<b>,</b> 191	0 We	st Virginia
	land ow		10a. State 10b. County		10c. City, Town	n or Loca	ation					10d. Inside City Limits
	Mary -f sh	to	Md. Montg	omery	Sil	ver	Spring					1 X Yes 2 No
	r 28a	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What	Country?
	h with	ai D	15004 Layhill R	oad			20906			U.:	S.A.	
	deat	ner	11. Marital Status	12. Was Decedent E		13. W	as Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		4. Race - Ar	merican Indian,
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "neturel; or items 23s or 28s-f show other treumatic event, the Marical Exeminet must be notified at	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		。1944 <b>-</b> 1946	1	Tes, specify Cuba	Specify:	nican, etc.)	s	Black, WI	White
P	netur	Completed	15. Decedent's	Education	16a.	Decede	nt's Usual Occup	ation	vin a	16b. Kind	d of Busines	ss/Industry
21	thin 7 e. an "n	apple .	(Specify only highest (Secondary (0-12)	College (1-4or 5-		life. DO	O NOT use retired		ang	_		
21	filed wi Hygien other th ent, Ine	Son	8		Adn	nini	strative	Officer				t of Commerce
<u>n</u>	tal Hid oth	Be	17. Father's Name (First, Middle, La	,				18. Mother's Nam			,	
<u>X</u>	should be and Mental marked o umatic eve	၉	Joseph I. Huch,					1.00	eth M.			
Maryland	12 st h and 7 is m treum		19a. Informant's Name/Relationship			•		and Number or Ru e Road, B				
	1 and Health em 27 ther tr		Kimberly A. Broo	ks/Attorney	20b. Place of	Disposi	ition (Name of	-		•		or Town, State
altimore,	permit. Pages Department of I Importent: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		!	olit		atory 200			ALex	., Va.
Balt	permit. Departimport any injur		21. Signatur of Fureral Service U	rensee				ss of Facility Densin Ave				. 20007
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused in	the death. Do n	_						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition			Неа	ert Disea	ase				Onset and Death
	/Medical		resulting in death)	a	consequence		ire proce					-
	Examiner		Sequentially list conditions,	b								
	р <del>;</del>	iner	if any, leading to immediate cause. Enter Underlying		consequence o	of):						
	icate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last	C	consequence	of):						
38760,	be ex ician burial	三田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田		Due to (or as a	Consequence	J1 j.						
87	physic the	dical	•	d								
_	eath certifi attending p for use as		IF FEMALE:	23c. If yes, outcome of	of pregna <i>n</i> cy					25	3d. Date of o	telivery
Box	death certif e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death		ctopic pregnancy Other (specify)			20	Month	Day Year
0		nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
٥.	The law requires that the ste has been signed by the bage 2 should be detache	by Pł	Part II. Other significant condition	s contributing to death bu	t not resulting in	the und	derlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute	to the cause of death?
rds	quire in sig uld b								1 🗆 '	∕es 2 <sup>X</sup>	No 3 🗆	Probably 4 Unknown
Records,	aw requ s been 2 shouk	Completed							24a. Was	an	24b. Were	autopsy findings available to completion of cause of
Re	The law ate has page 2:	mo			_				autor perfo	rmed?	death	es 2 No
of Vital		a	25. Was case referred to medical					26. Place of Dea				
<b>-</b>	dis di	To B	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1 ☐ Inpatient	at 2 ER/Out	tpatient	3□ DOA Oth	er: 4 🗆 Nursing He	ome 5 🔀 Resid	dence 6	□Other (S	pecify)
0	ding Phi After thi funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. T	Time of njury	28c. Injun Wor	y at k?	28d. Describe I	now injury	occurred	
0	ttendir death. ctor: Al y the fu	catle	2 ☐ Accident investiga					Yes 2 □ No				
Division	or Attend after death Director: /	Certification:	3 Suicide 6 Could no 4 Homicide determin		ry - At home, fai . <i>(Specify)</i>	rm, stree	et, factory, office		28f. Location (S City or Tox	Street and vn, State)	Number or	Rural Route Number,
_	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 X Certifying (Check only 2 Nedical E)	Physician: To the best of caminer: On the basis of	f my knowledge	e, death o	occurred at the timestigation in my o	ne, date and place,	and due to the	cause(s) a	nd manner	as stated.
	the F the F the F	Medical	one)	and manner stat	ed.							
	To To Con	~	29b. Signature and title of certifier	1 2 2 2	4 D - D	,	29c. Licens	3496				onth, Day, Year)
,	6 5+1			n Aholi				J470		APTI.	1 29,	2005
	•		30. Name and address of person with Mohammad Khali					eaton, M	d 2000	5-470	6	
	Sta	te	31. Date filed (Month, Day, Year)					cacon, m		, 770		
	Registr		MAY 0 3	2005 Strew	r's Signature	A COM	MEL					
						_						

			State of Maryland / Department of Health and Mental Hygiene 0 05 656  Certificate of Death  Reg. No.
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Heidi Lynn Hardy  2. Date of Death Month Day Year April 30, 2005 0:07 a.
	Examir Funeral Director		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  4d. Anne Arundel  5. Social Security Number  6. Sex
	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	with the Ma a or 28a-f a	Directo	Md. Anne Arundel Crofton  10e. Street and Number  1083 Fallonfield Court  1083 Fallonfield Court  109. Critizen of What Country?  11883 Fallonfield Court  109. Clitzen of What Country?  11883 Fallonfield Court
980	within 72 hours after death with the Maryland ene. than *natural', or Items 23a or 28a-f show fre Modical Exertings the modified at	by Funeral Director	1683 Fallonfield Court  21114  USA  11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ₺ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ₺ No Specify: White
21215-0036	d within 72 ho giene. er than "natur itte Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  1   16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Management analyst  US Gov't.
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, the Max	To Be C	17. Father's Name (First, Middle, Last)  Jack Edward Hardy  18. Mother's Name (First, Middle, Maiden Sumame)  Virginia Ann Daher
	of Healt item 2		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  10549 W. Rasberry Mountain, Littleton, Colorado  20a. Method of Disposition  1X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  10549 W. Rasberry Mountain, Littleton, Colorado  20c. Location - City or Town, State  20c. Location -
Baltimore,	permit. Page Department of Important: If any injury or ance.		21. Signature of Fungal eprice Licensee  22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Maryland 20715
	Physician // Medical Examiner physician sud physician sud physician sud physician sudding physician su	ıl Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
P.O. Box 68760	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
Records, 1	aw requires s been sign 2 should be	Completed by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
of Vital F	Phyaician: The lathis certificate harral director, page 3	To Be Col	25. Was case referred to medical examiner? 1X Yes 2 No 12 Yes 2 No 12 Yes 2 No 14 Nursing Home 5 Residence 6 Other (Specify)
Division o	ling After fune	Certification:	27. Mannyr of Death 1 Hatural 5   Pending investigation 3   Suicide 4   Homicide   Homicide   Suicide 4   Homicide   Homicide   Suicide   Homicide   Suicide   Homicide   Homicide   Suicide   Homicide   Suicide   Homicide   Suicide   Homicide   Suicide   Suicide   Homicide   Suicide   S
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medicai Ce	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the He within 24 To the Fe complete	Me	29b. Signafure and title of certifier  OCME  29d. Date signed (Month, Day, Year)  MAY 1, 2005
K	(5) Sta	ate_	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  HI Penn Street Baltimore, Maryland 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature
	Regist		MAY 0 3 2005 State & Species

		Registrar  1. Decedent's Name	(First, Middle	le, Last)				rtificate				2. Date of De		W 10 10	3. Time	of Deat
Physicia			ANZEGE									Month MAY	Day -	Year	83	3574
/Medic Examin		4a. Facility Name (If I			et and numb	ver)		4b. City, 7	Town, or	Location of	of Death	my -	4c. Cc	ounty of Dea		
Lxamiii		Doctor's	Hospi	ta1				Laı	nham				Prin	nce Ge	eorge's	
Funeral	2	5. Social Security Nur		6. Sex		Age (In yrs. I	last birthday)	If Under		If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9. Bi	rthplace (State	or Fore
Director		214-48-82	276	1 L M	2 <b>X</b> ) F	79	Yrs.	Months	Duy 3	110010		June 29		5 Po.	land	
>		Usual Residence of D	Decedent 10b. County	,		10c Cib	y, Town or Lo	ncation							10d. Inside	City Lin
shor	-	Toa. State	,													s 21X
Sa-f	Director	MD	Princ	e Geo	rge's	Upj	per Ma						10- Citi	f 18/h - 1 C		
or 2	Dire	10e. Street and Numi						10f. Zip		,				on of What C	ountry?	
8 23e	ral	3209 Marc	cando				0 140		2077		-:-0 /0			USA	erican Indian.	
ltem or o	Funeral	11. Marital Status	d OW Man		Armed Force		.5.   13.	If Yes, spec	ify Cuba	n, Mexican	gin? (Spi 1, Puerto	ecify Yes or No Rican, etc.)	)-   14.	Black, Wh		
or anni	by F	1 Never Marrie		.	1 Yes 2 If Yes, Give Year or Date	_		1□Yes 2	X No	Specify:			S	pecify:	White	
tura			15. Deceden				16a Dece	dent's Usua	Occupa	ation			16b. Kind	of Busines		
edic c	Completed	(Specif	y only highe:	st grade co	ompleted)		(Give	kind of wor DO NOT us	k done d	luring mosi	t of work	ing				
ther thai	E	Elementary/Secon	dary (0-12)		College (1-4	or 5+)	Hom	emake	r				Own I	Home		
ent,	BeC	17. Father's Name (F	irst, Middle,	Last)			11011	· CIII CITC		18. Mothe	er's Name	(First, Middle	·			
ked c	To B	Casimir	Marko	wski						Emi	ilia	Grabow	iecki			
mat	-	19a. Informant's Nan			Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Run	al Route Numb	er, City or T	Town, State,	Zip Code)	
27 Js r trau		Eliane P	Janz	egers	. Daus	ehter	3209	Marca	ando	Lane	e. Ur	per Ma	rlboro	o, Mar	yland	207
important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Dispo	osition			20b. P	Place of Dispo	osition (Nam	ne of			Date			r Town, State	
Important: If it any injury or c		1 X Burial 2 □			oval from St	ate	rt Lin			1	15/05	/2005	Brant	twood	Marv1	ano
injur Pe		21. Signature of Fun		1		101						ch's F				2110
lmpo any ir once		1	10	1.11	,							ue, Hya			-	
		23a, Part1. Enter the	diagona	wing												nd
ledical		shock, or heart Immediate Cause (F dis lase or condition resulting in death)	lailure. List inal	t only one of	Due o (or	neTa	uence of	ter the mode	e of dying	AVE	0	nom	ato	1 15, 'ζ	Approxim Interval B Onset an	ate etwee
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** April 2005 11:57 AM Johnson /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 26, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1914 North Carolina Months Hours 1 M 2 X F Yrs. 90 Director 577-16-6586 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County the Medical Examiner must be notified at Yes 2 No Director Centerville 28a-1 Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 15801 Phillips Oak Drive 20868 USA or items 23a Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 X Widowed 4 ☐ Divorced naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th. Domestic Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental P is marked of Willie MUrphy Laura Staton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: if item 27 is m any injury or other treum 6707 5th. St. N.W. Washington, D.C. 20012 Lena S. Dozier/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Lincoln Memorial Cem. 5-3-05 Suitland, MD. \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility MArshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th. St. N.W. Wash. D.C. 20011 mais 23a. Part1. Exter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) many years Physician Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titlated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2K No Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 

Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 🔀 No this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No М within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ö Hospitel 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

R 6

Maryland 21215-0036

Baltimore,

Box 68760,

Division of Vital Records, P.O.

State Registrar MAY 0 3 2005

Bhojraj, M.D.

R. G.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 23181

April 28, 2005

			For State Registrar	State of Ma	ıryland		irtment : <i>tificate</i>			lental Hy	gien Reg. N	Em 4 1.3	5	16661
			Decedent's Name (First, Middle, L.)	ast)			imouto	0, 50	-	2. Date of D	eath		V	3. Time of Death
	Physicia /Medic		RONALD J.	KISNER						APRIL	30,	2005	Year	6:45 A M
	Examin		4a. Facility Name (If not institution, gi						cation of Death		4	c. County	of Death	
			2708 MILES AVEN 5. Social Security Number 6.		(In yrs. las	st birthday)	If Under 1		IMORE Under 24 Hrs.	8. Date of Bi	rth		9. Birtho	lace (State or Foreign
	Funeral Director		220-30-3331	1 □XM 2 □ F		9 Yrs.	Months I	Days H	lours Min.	SEPT. 8	ay, Yea		WEST	VIRGINIA
_	pud *		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation						1	0d. Inside City Limits
	Manyla febo	ţo	MD		,,		TIMORE							1)(D)Yes 2 □ No
	h the	Director	10e. Street and Number				10f. Zip C	ode			10g. (	Citizen of W	hat Coun	itry?
	ath wit	ralD	2708 MILES AVEN						211			USA		
	72 hours after death with the Marylan reatural, or Itams 23a or 28a-f show ofcal Examinet mast be notified at	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?		. 13. \	Was Deceder f Yes, specify	of Hispa Cuban, A	nic Origin? (Sp Mexican, Puerto	ecify Yes or N Rican, etc.)	0-		k, White,	an Indian, etc.
30/05 5 AM <b>5-0036</b>	al', or	þ	3 ☐ Widowed 4 ☐ Divorced	1 YYes 2 □ N If Yes, Give Year or Dates:	.0		Yes 2	XNo S	Specify:			Specify.	WH	ITE
/30/05 +5 AM 15-003	"natural",	Completed	15. Decedent's 8 (Specify only highest g	Education rade completed)		16a. Deced	ient's Usual (	Occupatio	n ng most of work	ing	1	Kind of Bu		
04/ 6:4 121	within ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5	+)		AINTER				, K	ESIDE COMM	ERCI	
DOD:04/3( TOD:6:45 and 21215-	i Hygi othar ent, I	Be Co	17. Father's Name (First, Middle, Las	t)				18	. Mother's Name				ө)	
\Z \Z \Z \z	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked othar than "natural", or Itams 23a or 28a-f show aumatic event, the Modeal Experient marke notitied at	ToB	DAVID T. KISNEF	?					CORINNI	E UNDEF	WUU	D		
DOD:04/ ner TOD:6:4 Maryland 2121	12 sho h and 7 is m traum		19a. Informant's Name/Relationship L. ANN CHAMBERLIN KI						Number or Run				State, Zip	Code)
_	Healt Healt tem 2		20a. Method of Disposition	5NEIV 31 003E	20b. Pla		sition (Name natory or oth		1 1	Date		Location -	City or To	own, State
	Pages nent ol ant: If i ury or		XX Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec				EMETERY		MAY_3 2005	,		MART	INSBUF	RG, WV
Ronald Kis	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked othar than any injury or other traumatic event, Item 2058.		21. Signature of Funeral Service Lice	ensee		22	Name and BROWN FL	Address o INERAL	HOME, P.	O. BOX 8	21 <b>,</b> 254	327 W	. KINO	G ST.,
M. M.	et.		23a. Part1. Enter the disease, or conshock, or heart failure. List on	v one cause on each lin	10			of dying, s				02		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	i ME	TAS	STA	TIC	Li	ING	CAN	Œ	R	ó	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):								
1	JW-5	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseque	ence of):								
	acuted ind transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c										
68760,	icate be executed physician and s the burial-transit	al Ey	resulting in doubly bust	Due to (or as	a conseque	ence or):								
687	ifficate g phys as the	edlcal		d										
Вох	eath certifi attending for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic preg	nancy				23d. Date Mor	e of delive	ery Day Year
О. Е	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ath 5	Other (spec	:ify)						ouy rour
Division of Vital Records, P.O.	s that the	by Ph	Part II. Other significant conditions	contributing to death b	ut not result	ting in the u	nderlying cau	ise given i	n Part I.	23e. Did	tobacc	o use contr	ibute to th	ne cause of death?
ords	en sig	ed b								1)	Yes	2 🗆 No	3 🗌 Prob	ably 4 Unknown
Seco	law re nas be e 2 sho	Completed									opsy	24b. V	Vere auto prior to con leath?	psy findings available mpletion of cause of
al H	sician: The law s certificate has t lirector, page 2 s									1 Tes		No 1	Yes	2 No
Vit	/siciar s certif	o Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum No	Hospital:	nt 2□E	R/Outpatier	nt 3 DOA	Other	<ol> <li>Place of Deat</li> <li>Wursing Ho</li> </ol>	- 0		6 □Othe	er (Specif	iv)
n of	ng Phy Iter thi	J: L	27. Manner of Death  Natural 5 Pending	28a. Date of Inju (Month, Da	rv 2	28b. Time o		. Injury at Work?		28d. Describe				
siol	tendir leath. tor: Al the fu	catle	2 Accident investigate 3 Suicide 6 Could not	ha			М	1 🗆 Yes	2 □ No	Olf Location	(Ctrant	and Mumb	or or Bur	al Route Number,
Divi	after of Direction by	Certification:	4 Homicide determine		ury - At non c. <i>(Specify)</i>	ne, rarm, sti	eet, factory,	опісе		City or To	own, St	ate)	er or mura	i noute ruinper,
P	To the Hospital or Attending Physician: within 24 hours after death.  To tha Funaral Director: After this certifica completely filled in by the funeral director, to	edicai C		Physicien: To the best aminer: On the basis of and manner sta	examination									
	To the within to the comple	Mec	29b. Signature and title of certifier	/ A .				License n			29d. [	Date signed	(Month,	Day, Year)
			> Ewis	e MD			1	)16	354		MA	Y 1,	20	05
31	H-1		30. Name and address of person wh	_	eath (Item :	23a) (Type,	Print)  CATO	NA	VE B	ALTIM	202	EM	0 6	05
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Registr	ar's Signatu	re f.	neke							

DHMH 17 Rev 1/2001

			1 - For State of Maryland / D	epartment of He Certificate of D		Hygier	/ 11 15	16662
			1. Decedent's Name (First, Middle, Last)			of Death	2011 Vans	3. Time of Death
	Physicia /Medic		GEORGE KLIGFI	ELD	APR	ÏL 29,	2005 Year	7:37 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or t	Location of Death		4c. County of Deatl	h
			1799 E. JEFFERSON STREET, #208	ROCKVIL			MONTGOM	ERY
	Funeral Director		051-05-6582	hday) If Under 1 Year Months Days	Hours Min (Mor	of Birth hth, Day, Yea ST 8,	9. Birtl Co. 1912 CON	nplace (State or Foreign untry) NECTICUT
	pu *	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
	show	5						1 Yes 2 No
	Ne M	Director	MARYLAND MONTGOMERY RO  10e. Street and Number	CKVILLE 10f. Zip Code		100	Citizen of What Co	71
	death with the Maryland rms 23a or 28e-f show	급	1799 E. JEFFERSON STREET, #208	20852	1		ITED STAT	•
	eath	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.				14. Race - Ame	
	ter d	딢	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	100	spanic Origin? (Specify Yes , Mexican, Puerto Rican, e	tc.)	Black, White	e, etc.
3	hours after turat', or ite	þ	3 ▼ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No	Specify:		Specify:	WHITE
212-0036		Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupat (Give kind of work done du	tion	16b	. Kind of Business/	Industry
7	within 72 ene. than "na	ple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	and most or working			
7	filed wi Hygien other th	S		NGINEER			RIVATE IN	DUSTRY
yland	m - 0 %	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name (First,	Middle, Maid		
	should be nd Menta marked imatic ev	ဥ	BENJAMIN KLIGFIELD		ESTHER		LOEVSKY	7.0.11
Mar	2 sh and is m raum				nd Number or Rural Route			
	l and lealth im 27 her t			911 BARGATE Disposition (Name of	COURT, ROCK		MARYLAN Location - City or	
<u>0</u>	95 = 50		1X Burial 2 □ Cremation 3 □ Removal from State cemeter	y, crematory or other place	)			
	t. Pa tmen tent:				NS. 5/2/2005		NEY, MARY	LAND
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic evone.		21. Signature of Funeral Service Lidensee	EDWARD SAGE 1091 ROCKVI	s of Facility L FUNERAL DI LLE PIKE, RO	RECTIO CKVILI	ON, INC. LE, MD 2	0852
			23a. Bart 1. Enter the disease, or complications that caused the death. Do n shock, or heart fill re. List only one cause on each line.	ot enter the mode of dying	, such as cardiac or respira	atory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final) disease or condition a CONGESTIVE HEA	RT FAILURE				Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of	n):				
	Examiner		Sequentially set conditions b. ARTERIOSCLEROT		CULAR DISEAS	E		
	P #	Iner	Scape distribution in the state of the state	d):				
	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	of).				
/60,	be executed sician and burial-transit		Bue to (of as a consequence of	").				
189	physi the l	dlcal	d					
ox e	death certificate e attending phys d for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of del	iverv
n	atten for u	clan	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
o.		ysl	1 Yes 2 No 9 Unknown					
1	res that igned by be deta		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	n in Part I. 23	e. Did tobaco	co use contribute to	the cause of death?
ds,	uires sign Id be	d by				1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Unknown
Record	The taw requires that the tite has been signed by the bage 2 should be detache	Completed			24.	a. Was an	24b. Were au	utopsy findings available
Re	The taw cate has	ш				autopsy performed	? death?	completion of cause of
Vital		e Cc	25. Was case referred to medical		26. Place of Death (Check	Yes 2X	No I I I I I I I I I I I I I I I I I I I	2LI NO
	Physicien: rthis certificaral director,	To B	examiner?	tpatient 3 DOA Othe			e 6 □Other (Spe	cify)
ō	Phy er this eral o		27. Manner of Death 28a. Date of Injury 28b. T	ime of 28c. Injury			njury occurred	
o	Attending For death.  ector: After by the funer	atlo	1X Natural 5 ☐ Pending (Month, Day 1941) If 2 ☐ Accident investigation		r res 2□No			
Division	or Attendiater death Director: A	ific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Loc	ation (Stree	t and Number or Ru	ural Route Number,
	s after s after si Direct	Certification;	Dunding, Std. (Diposity)					
	To the Hospitel or A within 24 hours after To the Funerel Direction Completely filled in b	Medical	29a. Certifies (Check of or one)  1 ☐ Certifying Physician: To the best of my knowledge 2 ☑ Medical Examiner: On the basis of examination and manner stated.	, death occurred at the tim d/or investigation, in my op	e, date and place, and due iinion, death occurred at th	to the cause e time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	o the	Me	29b. Signature and title of certifier	29c. License	number	29d.	Date signed (Mont	h, Day, Year)
l	F ≤ F Ö		M.D (DME)	)   D1523	6	ΔΤ	PRIL 30,	2005
	12		30. Name and address of person who completed cause of death (Item 23a)			111	50,	
				CKVILLE PIKE	, ROCKVILLE	, MARY	YLAND 20	852
	Sta		31. Date filed (Month, Day, Year)  32 Registrar's Signature	Snall)				
	Registi	ar	31. Date filed (Month, Day, Year)  MAY 0 3 2005  32 Registrar's Signature	7				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1 Decedent's Name (First Middle:Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll | If Under 14 Hrs. | S. Date of Birth (Month, Day, Year April 11, 10) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1⊠M 2□F 88 Vrs Director 214-12-7335 1917 Washington, D.C. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner nust be notified Director 1 ☐ Yes 2 No Maryland Frederick Monrovia 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3934 Shakespeare Way items 23a 21770 United States filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: White þ WW II 3 ☐ Widowed 4 X Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) 12 Painter/Contractor Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F Pages 1 and 2 should be Claude W. Lane Madge Mildred Caton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If itam 27 Alice J. Kenefick/Daughter 6633 Windridge Road, Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cometery, cromatory or other place)
Parklawn Memorial 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 5, Rockville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 Park Funeral Service ponsee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 any ir M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ate has page 2 s autopsy perform certificate 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to redical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 72 moatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After 1 Tatural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) +1 10 who completed cause of death (Item 23a) (1 restminsty MD State 2005 Registrar

Please Type or Print in Black Indelible lak. Ensure All Copies Are Legible. Anerd Item 2 per phys Item par in 843 5 20 0 vt state of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Mo**29** Day 04/<del>19/</del>2005 1. Decedent's Name (First, Middle, Last) 2:00 Mary J. Ladas 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Derwood 5922 Serenity Lane 8. Date of Birth (Month, Day, Year) 09/14/1912 If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Hours 1 ☐ M 21 € F Sparta, Greece 159-26-3622 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 ☐ No Montgomery Derwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20855 USA 5922 Serenity Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker -61 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pota Zavras William Athans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5922 Serenity Lane, Derwood, MD 20855 Gregory Ladas / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 05/03/2005 Silver Spring, MD Gate Of Heaven 22. Name and Address of Facility Joseph Gawlers Sons, INC. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. Nw, Washington, DC 20016 MO1378 or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the only one cause on each line. 2 Part1. Enter le d'es Approximate Interval Between Onset and Death Immediate Cause (Final 4 Years Non Small Cell Lung Cancer disease or condition resulting in death) Due to (or as a consequence of): 4 Months Pleural Effusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 Z No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year)

29c. License number

D35996

29d. Date signed (Month, Day, Year)

04/29/2005

The law requires that the death certificate be executed burial-transit and Box 68760. physician the use as signed by the a P.0. Division of Vital Records, been si page 2 certificate or Attending Physicien: After thi funeral To the Hospital or Attendit within 24 hours after death. To the Funerel Director; A the

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**Physician** 

/Medical

**Examiner** 

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r then "neturel", or Items 23e or 28e-f ehow the Modical Examiner must be notified at

death with the Maryland

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygie Importent: If Item 27 is marked other tieny injury or other treumatic event, III. 2016.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Breast Cancer 25. Was case referred to medical Be examiner' 1 ☐ Yes 2 XNo 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

unds /11

2730 University Blvd. #400, Wheaton, MD 20902 Linda M. Burrell, MD 37 Registrar's Signature 31. Date filed (Month, Day, Year) MAY 0 3 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For State Registrar	State	of Marylar		artment of H		nd Mental Hy	giene	5	66	55
	Dhusisi		1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath Day	Year	3. Time of	Death
	Physici /Medio		Alice	Mary	<u></u>	Me	ehallick		May	5,	2005	3:45	$A^{M}$
	Examin		4a. Facility Name (If not institution	, give street and n	ımber)		4b. City, Town, or	Location of I	Death	4c. County	of Death		
			Homewood of Wil				Willia				ingto		
	Funeral Director		5. Social Security Number 168–22–1145	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	th ly, Year) 0, 1927	9. Birthpl Coun Penns	ace (State o try) sylvan	r Foreign ia
	and w		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	cation		,			Od. Inside Ci	
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	the N	Director	10e. Street and Number	Ingcon	110	gersto	10f. Zip Code			10g. Citizen of	Mhat Coun		
	3a or	0	11400 Stonecrof	t Court	210B		21742					uy:	
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36	filed within 72 hours after death with the Maryland Hygiene. kther then "neturel", or Items 23a or 28a-f show ent, the Medical Exercises to rolling at	by Fur	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed F ed 1 ☐ Yes If Yes, G Year or I	2∭XNo ive	1	v	n, Mexica <i>n</i> , F Specity:	n? (Specify Yes or No Puerto Rican, etc.)	Specifi	ck, White, e	etc.	
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<u>yla</u>	ould to	To	Andrew Kowalczy						ry Kowalcz			·	
, Maryland	and 2 sh elth and 1.27 Is m er treum		19a. Informant's Name/Relationsh Patricia Friend		2				or Aural Aoute Numbe ., Hagerst		State, Zip		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 271s marked other then "neturel", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Expression and other treumatic event, the Medical Expression and once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	3 □Removal from	State	cemetery, crer	sition (Name of natory or other place		Date	20c. Location -			
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	/Medic		NELLIE Mc										May	1		005	05:55	A <sup>M</sup>
	Examin	ier	4a. Facility Name (If not in								Location o	of Death			County		_	
-	Euparal		Carriage Hi 5. Social Security Number				n yrs. la	st birthday)	If Unde	hesd:	If Under 2		8. Date of Bir	th	ontgo	9 Birtho	lace (State or	Forei <b>a</b> n
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ould t	Mentarka	2	John P. McL										Ann Sir					
<b>1</b> 2 sh	Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28a-f show any injury or other treumatic event, the Medical Examinar must be invitibed at once.		19a. Informant's Name/Re										Route Numbe					620
, <u>a</u>	Healt tem 2 other		John McLeis 20a. Method of Disposition		new		20b. Pla	ce of Dispo					GLASOI Date				Land 21 own, State	030
30,85	ant of at: If i		1 🔀 Burial 2 □ Crer 1 □ Donation 5 □ C			State		netery, crei Linco				05/0	4/2005	Br	e <b>n t</b> wo	od.	Maryla	nd
mit. F	oortar injur		21. Signature of Funeral				FOLU						ch's Fu					iid
ž ž	fmpo any is		Men L.	Technel				4	739 I	alti	more	Aven	ue, Hya	atts	ville	e, Ma	aryland	
			23a. Phr 1. Enter the dise strick, or heart failur	ease, or comp re. List only o	ications that	caused the	e death.	Do not ent	er the mo	de of dying	g, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between	een
	nysician		Imme liate Cause (Final disea e or condition		а Нур	erter	siv	e Hear	rt Di	seas	e						Onset and De	atn
	Medical xaminer		resulting in death)			(or as a c		1										
		io.	Sequentially list condition	is,		tic S										-		
utad	ansit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	-				Fail	ure									
be executed	an andrial-tra		resulting in death) Last		U	(or as a c												
ate be	hysicia he bu	Ical			d													
entificat	attending physician and for use as the burial-transit	Physiclan/Medl	IF FEMALE:		20- 14													
ath c	attenc for us	lan	23b. Was decedent pregr in the past 12 month	iarit		birth 2 [ nant at tim	Fetal	death 3	Ectopic p	regnancy					23d. Date Mor		ery Day Ye	ar
) å	y the	nysic	1 □ Yes 2 🌠 No 9 □ Unknown		9☐ Unkr		10 01 002	3	J Other (2	pochy)								
s that	been signad by the attendin should be detached for use	by Pt	Part II. Other significant	conditions co	ntributing to o	death but n	not result	ting in the u	nderlying	cause give	an in Part I.		23e. Did t	obacco	use contr	bute to tl	ne cause of dea	ath?
w requires	an sig		Hyperthyro	idisum									1 🗆 '	Yes 2	□No	3 🗌 Prob	abiy 4∭Un	known
a ve	as be	plet											24a. Was		24b. V	ere auto	psy findings av	railable
The off	ate h	Completed												rmed? 2X No	ď	eath? □ Yes		
cian:	ector,	Be	25. Was case referred to examiner?	F	Hospital:					Otho			(Check only o					
Phys	th. : After this certificate has b s funeral director, page 2 st	2	1 ☐ Yes 2 🔀 No 27. Manner of Death		28a. Date	· · · · · · · · · · · · · · · · · · ·		R/Outpatier 28b. Time o			4120140		me 5 Resi 28d. Describe				y)	
ding	th. After fune	tlon		Pending investigation	(Mor	nth, Day Y	ear)	Injury	M	28c. Injury Work 1 🗀 `	<br Yes 2 □ I				.,			
Atter	er death rector: by the	ertification:		Could not be determined	286. Flac			ne, farm, sti	reet, facto	ry, office			28f. Location (	Street au	nd Numbe	er or Rura	l Route Numbe	9 <i>r</i> ,
2 8	s afte	Cert	4 B Hornolds		Dulic	ling, etc. (	Specify)						Ony or rol	mi, Olan	5)			
To the Hospitel or Attending Physicien: The law requires that the death certificate	within 24 hours after death.  To the Funerel Director: A completely filled in by the t	edical	29a. Certifier 1 X C (Check only 2 N one)	Certifying Phy fedical Exam	iner: On the I	basis of ex	aminatio	ledge, deat on and/or in	h occurre vestigatio	d at the tim n, in my op	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s date an	) and mai d place, a	nner as s nd due to	tated. the cause(s)	
o the	o the	Mec	29b. Signature and title of	f certifier	and mar	nner stated	J.		29	c. License	number			29d. Da	ite signed	(Month,	Day, Year)	
-			> 'In	ouns	U.	Pusa	all	7 -		D004	7330			Mav	2,	2005		
1	20)		30. Name and address of				-		Print)	2004	. 550			Litty	_,		onari.	
			Thomas Jose		_				Rocl	kvill	e, Ma	ıry1a	ind 208	352				
	Sta Registr		31. Date filed (Month, Day		2.	Registrar's	Signatu	ire foo	L)									
			י ויתויו	U			1	678										

				artment of Health and Mo		6.000	16668
			Decedent's Name (First, Middle, Last)		2. Date of Death	eg. No.	3. Time of Death
П	Physici		Charles R. Miller		Month April	30, Year 2005	6:30 P M
3	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Whili	4c. County of Death	0:30 F
	LAdilli	ie:	203 East 4th Street	Frederick		Frederi	ck
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth		
	Director		217-28-1115 1 XM 2 F 71 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Dec. 13,	Year) Cour. 1933 Mary	lace (State or Foreign stry) 1and
	p		Usual Residence of Decedent		15,	1999 1141)	20114
	how	_	10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
	e Ma	cto	Maryland Frederick Frede	rick			1 X Yes 2 □ No
	or 24	Oire	10e. Street and Number	10f. Zip Code	10	og. Citizen of What Cour	itry?
	23e	ral	203 East 4th Street	21701		United St	ates
	r de s	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	s afte	by Fi	1 Never Married 2 Married 1 Myes 2 No	1 ☐ Yes 2 X No Specify:		Specify: Whi	
Ö	72 hours after death with the Maryland neturel', or items 23e or 28e-f show distal Exament must be truitled at	d be					
15	n 72	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	ng 1	16b. Kind of Business/Inc	dustry
12	within ene. than	шс	Elementary/Secondary (0-12) College (1-4or 5+)	struction Worker		Construc	tion
0	e filed within al Hygiene. I other than '		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First Middle M		CIOII
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or items 23e or 28a-f show any injury or other traumatic event, it a Medical Exam net must be richified at any injury or other traumatic event, it a Medical Exam net must be richified at angles.	To Be	Unknown		M. Dixo	•	
ar	2 sho and is ma			ng Address (Street and Number or Rural			Code)
	and sealth m 27			East 4th St., Frede		D 21701	
Baltimore,	Pages 1 nent of H ent: tf ite		20a. Method of Disposition 1 □ Burial 2 ②Cremation 3 □ Removal from State 20b. Place of Disposition	matory or other place)		20c. Location - City or To	wn, State
Eim	. Pa tmen tent: jury		`4 □Donation 5 □Other (Specify) Frederic	k Crematory   5/4/2		Frederick,	
3al	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Sta			
	70 F 4 0		( ourtney Stauffer	1621 Opossumtown			D 21702
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as carpiac or	respiratory arre	st;	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	bstuctive I'm	morning	136	Onset and Death
	/Medical Examiner		resulting in death)  Due to (o a consequence in the	1.	- 5		
		Ļ	Secuentially list conditions from the secuential by list	moley	111		mer
	be sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	/		(	)
_	and and II-trar	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	aiE					
687	icate phys s the	dicai	d.				
	death certifica e attending pl d for use as t	Physician/Me	IF FEMALE: 23b. Was decoded program: 23c. If yes, outcome of pregnancy			22d Date of delive	
Вох	atter for u	ciar	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delive Month	Day Year
o.	0 0 0	iysi	1 Yes 2 No 4 Pregnant at time of death 50 9 Unknown	Other (specify)			
<u>α</u>	requires that the		Part II. Other significant/conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
ds,	uires than signed I	d by	Tuna Cincer	, ,	1 Yes	s 2□No 3□Prob	ably 4 □Unknown
00	w requir been si should	ete			24a. Was an	24h Wasa autor	nov findings qualishts
Ä	e la has	Completed	1	· · · · · · · · · · · · · · · · · · ·	autopsy	prior to con	osy findings available npletion of cause of
ā		ပို	25 Was ago related to modical		1□ Yes 2	ZNo 1 ☐ Yes	2□ No
Vital Record	sicien: certifici irector,	o B	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inputient 2 ☐ ER/Outnatie	26. Place of Death			
of	Phys	$\vdash$	1 ☐ Yes 2 ☐ No ☐ ITOSPITAL 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time of			nce 6 ∐Other <i>(Specif</i> ) winjury occurred	)
Division of	ding P th. After I funera	ţ	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	f 28c. Injury at 28 Work?  M 1 ☐ Yes 2 ☐ No		,,	
<u>IS</u>	I or Attending Physicien: after death. Director: After this certific in by the funeral director.	fica	3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury. At home farm of		8f. Location (Stre	eet and Number or Rura	l Route Number.
ă	el or s after of in t	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospitel or Atti within 24 hours after de To the Funerel Direct completely filled in by th	edical (	29a. Certifier Check only 2 Medical Exeminer: On the basis of examination and/or in	h occurred at the time, date and place, ar	nd due to the cau	use(s) and manner as st	ated.
	the hin 2 the F	Med	and manner stated.				
	5 ± 6 0	_	29b. Signafure and title of certifier	29c. License number	29	d. Date signed (Month, L	7
•	7		7011/2	D70010		V/// 2 2	2007
	ê		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print AVE / AVE F	-RED 1	10 21702	
	Stat	e	31. Date filed (Month, Day, Year)  32. Registrar's Signature		-/ !	•	
	Registra	_	MAY 0 4 2005	front ,			
_		-					

State of Maryland / Department of Health and Mental Hygiene

								Cen	tificat	e of	Death			Reg. N	<u> </u>	U	10	0/0
	Dhyoisi	25	1. Decedent's Name (First, Mic		•								2. Date of De Month		ay	Year	3. Tim	e of Death
	Physici /Medio		Carl Warı	en	Neutz	el							May	10	<sup>ay</sup> 200	)5	10:	: 45 AM
Ì	Examir		4a. Facility Name (If not institu	_									ocation of Dea		c. County			
			College Ma								Luth				Balt			
	Funeral Director		5. Social Security Number  212-20-0787  Usual Residence of Decedent	6. S	ex Mo 2□F	7. Age (In yr. 80		rs.	If Under Months	1 Year Days		24 Hrs. Min.	8. Date of Bi (Month, Di Feb.	rth 9v, Yea 8 <b>,</b> 1	925	Cour	olace (Sta ntry) yla:	nte or Foreign nd
	land m		10a. State 10b. Cour	ity		10c. (	City, Town	or Loc	ation							1	Od. Inside	e City Limits
	Mary Firsh	ģ	MD Balt	imo	ore	W	hite	На	a11								1 🗆 Y	∕es 2∭∑No
	h the	<u>e</u>	10e. Street and Number						10f. Zip	Code				10g. C	itizen of V	Vhat Cour	ntry?	
	th wit	alD	2648 Opens	shav	w Road				2	2116	51			τ	J.S.	Α.		
20	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28e-f show eny injury or other traumatic event, the Modical Exercities reset by rudified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ M 3 □ Widowed 4 □ Divord		12. Was Dece Armed Fo 1 X Yes If Yes, Giv Year or D	rces? 2 □ No /e	U,S.	if	/as Deced Yes, sped □ Yes	cify Cub	an, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	0-		e - Americ k, White,		
8	tural	edk	15. Deced			a(63.	16a. I	Decede	ent's Usua	al Occui	pation			16b.	Kind of Bu	usiness/In-	dustry	
Baltimore, Maryland 21215-0020	d within 72 giene. r then "na	Completed	(Specify only hig Elementary/Secondary (0-12	nest gre	College (1	1-4or 5+)		(Give k life. D	ind of wo O NOT u Ory	rk done se retire	during mos nd)	st of work	ing		stic			ture
g	al Hy othe vent,	Be C	17. Father's Name (First, Midd	e, Last)									e (First, Middle					
yla	Menta	ТоЕ	Carl Frede	ric	ck Neu	tzel					Al	ice	Miria	ım I	Pier	ce		
, Mar	end 2 shc valth end 127 is me er traume		19a. Informant's Name/Relation Lorraine Ne										el Route Numb , Whit					1
nore	ages 1 eant of He tr. If item y or other	20a. Method of Disposition  1 M Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)								ne of other pla Uni	ted eter	M	ay 14,		Location - hite			
altir	permit. P Departme Important eny injuri		21. Signature of Juneral Servi	Metn	22.	St Name ar	Cem	eter ess of Facili	7	J. Hart				-				
ш	9 Q F 9 9		J.J.X	w	lens	Loin							New F					
	Dhusisian		23a. Pert1. Erker the disease, slock, or heart failure. L	or com	plications that c one cause on e	aused the de ach line.	ath. Do no	ot ente	r the mod	le of dyi	ng, such as	cardiac	or respiratory a	arrest,		1	Approxi Interval Onset a	mate Between nd Death
	Physician /Medical		Immediate Cause (Final			PARKIT	1204.	1-	70.4	151	0.00							
	Examiner	)	disease or condition resulting in death)		a		(or as a c			SEA!	つた					1		
	D #	ner				240 10	(01 40 4 0	onooqu	101100 017.							1		
0,	es that the death certificete be executed igned by the ettending physician and be deteched for use es the bunel-transit	/Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ſ	b	Due to	(or as a co	onsequ	ience of):							1 1 1 1 1 1		1
68760,	rtificete b ng physic es the b	Medica	Cause (Disease or injury that initiated events resulting in death) Last	1	C	Due to	(or as a co	nsequ	ence of):									
Box	ith cer tendir or use				d												***	
E	e death he etter	Physician	Part II. Othar significant cond	tions c	ontributing to de	eath but not re	sulting in	the und	derlying c	ause gi	ven in Part	l.	23b. Did	tobacc	o usa coi	ntributa to	the cau	sa of death?
P.O.	hat th		DEMENTIA										1	Yes	21/2 No	3 🗆 Proi	bably 4	Unknown
ds,	signe d be	d by											24a. Was	an aut	oneu	24h W	ere auton	sy findings
Records,	The law requires that the ate has been signed by the page 2 should be deteche	Completed					alt and the second						perf	omed?	орзу	av co	ailable pri mpletion death?	ior to
œ.	The late ha	Son											10	Yes :	2 ÎZ No	10	]Yes 2	2□ No
of Vital	Physician: r this certific real director,	Be	25. Was case referred to medi examiner?	cal								e of Deat	h (Check only	one)				
Ž	hysic li dire	2	1 ☐ Yes 2 ☐ No		Hospital: 1 🗆 I	npatient 2	□ ER/Out	atient		DA		ursing Ho	me 5 🗆 Res	idence	6 □Oth	er (Specif	y)	
ion	27. Manner of Death  1 Natural 28a. Date of Injury (Month, Day Year)  28b. Place of Injury - Athere is the property of the pro							me of jury	M 2	28c. Inju Wo 1 □	ryat ⊮rk? ]Yes 2□		28d. Describe	how inj	ury occur	red		
Division	building, etc. (c						home, fari	n, stre	et, factory	y, office			28f. Location City or To			er or Rure	I Route N	Vumber,
	To the Hospital within 24 hours of To the Funeral completely filled	edlcal C	29a. Certifier 1 Cartific (Check only one) 2 Medic	ing Ph	ysician: To the ninar: On the ba and man	best of my kr asis of examir ner stated.	nowledge, nation and	death of	occurred estigation	at the ti	me, date ar opinion, dea	nd place, ath occurr	and due to the ed at the time	cause(	s) and ma nd place,	nner as s and due to	tated.	se(s)
	within To the	Me	29b. Signature and title of certi	fier					290	c. Licens	se number			29d. D	ate signe	d (Month,	Day, Yee	or)
			Curyan	So	ards re	D				D	16619			N	ray	10,	200	5
7	13		30. Name and address of person			e of death (Ite	em 23a) (1	Type, P	rint) EM	NA	RY x	1VE	. Lui	HER	eville	E, MI	). 21	093
	Sta Registr		31. Date filed (Month, Day, Yea		005	gistrar's Sig		h	رميد	P	,					,		
					-	A 9 " 100"												

DHMH 16 Rav 6/95

		•	1 = State   Registrar		Ć	ertificate of	Death		Reg. No.	0 0	100	1 1
			1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath Day	Year	3. Time of	Death
	Physicia /Medic		A1	nna Novack				May		2005	2100	P M
	Examin		4a. Facility Name (If not institution, giv	e street and number)			or Location of Dea	th		nty of Death		
			Union Hospital			E1kto				ecil_		
ı	Funeral Director		5. Social Security Number 6. S 206-12-7484	ех	e (In yrs. last birthda Yrs	Months Days			ay, Ye <i>ar)</i>	Cour	ilace (State or htry) Sylvan	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					0d. Inside Cit	v Limits
	shov	٦			-					,	1 ☐ Yes	
	the N	Director	Maryland Cecil  10e. Street and Number		Perryv	111e			10g. Citizen	of What Cour	ntn/?	
	Mith Be of		12 White Oak Dr	i		2190	2			ted Sta	•	
	death me 23	era	12 WILLE Oak DI.	12. Was Decedent	Ever in U.S. 1	3. Was Decedent of	Hispanic Origin? (	Specify Yes or No	o- 14. F	Race - Americ	an Indian,	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "netural", or Itama 23e or 28e-f show event, the Medical Exstrict must be notified at event, the Medical Exstrict must be notified at	by Funeral	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	40	1 ☐ Yes 2 ☐ No	ban, Mexican, Puè o <i>Specify:</i>	no Hican, etc.)	Spe	Black, White, c <i>ify:</i> Wh:		
2-0	72 hc	Completed	15. Decedent's E (Specify only highest gra		16a. De	cedent's Usual Occu ive kind of work done b. DO NOT use retir	upation e during most of wo	orking	16b. Kind of	f Business/In	dustry	
2	ne.	mpl	Elementary/Secondary (0-12)	College (1-4or 5	i+)				C1 -			
7	e filed within al Hygiene. I other then vent, the Mis		10 17. Father's Name (First, Middle, Last	)	3	eamstress	7	ıme (First, Middle		othing		
and	ould be f Mental H Marked of	Be c	Harry Sumadaka	,			Mary R		, maioon our	<i>(4.110)</i>		
<u>Z</u>	should the market market	P L	19a. Informant's Name/Relationship (	Type, Print)	19b. M	ailing Address (Stree			er, City or Tov	wn, State, Zip	Code)	
	nd 2 sith an 27 is rr treu		Michael A. Nova	ck/Husband	12	White Oak	Drive, B	Perryvil	le, Mar	yland	21903	
Baltimore,	ges 1 and 2 should but of Heelth and Ment if Item 27 is marked or other treumstice		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Discemetery, of	sposition (Name of crematory or other pl	ace) May	Pate 11,	20c. Locatio	on - City or To	own, State	
altim	permit. Peges Depertment of the Importent: If Ite any Injury or of Angles.		*4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licentary Control of the Control of th			oft Cemet 22.Name and Add Hicks Hom			Linwoo	od, Per	ınsy⊥va	inia
8	89 5 5 8		Daniel .	3 Hill	20	103 W. St	ockton St	reet, El	lkton,	Maryla	ınd 219	21
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each lir	10.	0					Approximate Interval Betw Onset and D	veen
	Physician		Immediate Cause (Final disease or condition	a degi	onella	Vneum lerotic	nonia				Onset and D	- Galii
	/Medical Examiner		resulting in death)	Due to (das	a consequence of):	1 7:	Han L	X				
		P	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):	Revolle	rearr	Diseas	e			
1	uted	min	Cause (Disease or injury									
ď	exection endingle	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):							
68760,	ite be iysicie	cai	(	d								
x 68	The law requires that the death certificate be executed ste hes been signed by the attending physicien end bage 2 should be detached for use as the burral-transit	Medical	IF FEMALE:									
Box	ath ce ttendi	-	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnan	су			Date of delive Month		'ear
0.	the a	Physician	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 Other (specify)						
<u> </u>	that the de ted by the a		Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying cause g	iven in Part I.	23e. Did	tobacco use c	contribute to t	ne cause of de	eath?
Vital Records,	uires sign ld be	d by	Diabetes	Mellitu	5			1 🗆	Yes 2□No	o 3 🗆 Prot	ably 4 🗹	nknown
000	w require been si should b	Completed		•	•			24a. Was	an 24	lb. Were auto	psy findings a	available
Re	The law sete hes page 2	omp						auto perf	ormed?	prior to co death? 1  Yes	mpletion of ca	use of
ta		0	25. Was case referred to medical				26. Place of De	eath (Check only			2010	
	rysic is ce direc	To B	examiner? 1 🗆 Yes 2 🗷 No	Hospital: 1 Impatie	ent 2 ER/Outpa	tient 3 DOA	ther: 4 Nursing	Home 5 ☐ Res	idence 6 🗆	Other (Specif	y)	
n of	Jing Ph J. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Tim y Year) Inju	y W	ark?	28d. Describe	how injury oc	curred		
Sio	att :: e	cati	2 Accident investigatio	10			JYes 2 □No	Tank I is				
Division	of or Attend efter death Director:	Certification;	4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, c. <i>(Specify)</i>	street, factory, office	9	28f. Location City or To	(Street and Nu lwn, State)	imper or Hura	ai Houte Numi	7 <del>0</del> 7,
	To the Hospitel or Atter within 24 hours efter de To the Funerel Directo completely filled in by th	Medical C	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Exam	nysician: To the best miner: On the basis o and manner st	f examination and/o	eath occurred at the r investigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time	cause(s) and date and place	manner as s ce, and due to	tated. the cause(s)	
)	To the To the comp	X	29b. Signature and title of griffier	ides 5	MI	7)	nse number 0 02336	22	29d. Date sig	5.6.	05.	
	8		30. Name and address of person who	completed cause of c	leath (Item 23a) (Ty	pe, Print)	S18 .	E 2 R	FOI	T no	2 2/0	2 1
	Sta		31. Date filed (Month, Day, Year)	2005 32. Poistr	ar's Signature	- I varin	y ory		- LE	راوس المار	リーイグ	<b>\</b> /
	Registr	ar	MAT T P	LUUS See	w K	(conti)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - State Ragistrar 5-3-05 Amend #27-Per MEO PCC cr Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 22:57 M 04 OS 2 101 Ocubu /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Med Baltimore UNIVERS it 16. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🕱 F 82 Months Days Hours Min. Director 12,1922 none Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If item 27 is marked other then "naturel", or items 23a or 28a-f show try or other treamstic event, Ire Mudical Experimental Les notified at any or other treamstic event, Ire Mudical Experimental Les notified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 XYes 2 No Completed by Funeral Director Maryland Prince Georges' Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 3313 Eritrea Madison Street 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2X No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Woldu 0cubu ဥ Assahalai Gebrkidan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is eny injury or other treu 6611 Adrian Street, Hyattsville, Md. 20784 Haregu G. Araya, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery May 9,2005 Asmara, Eritrea 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3447 14th Street N.W., Washington, D.C. 20010 Approximate Interval Between Model and Death , Bacon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Intracerebra Henorta disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner accid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as IF FEMALE CERTIFICATI 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Hinknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Winknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 1 NO or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pres 2 No P 1. Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After - ENatoral 5 Pending 4/28/05 1 Yes 2 Yo death. investigation SUBJECT FELL 2XXAccident UNKNEWN within 24 hours after death To the Funeral Director: Location (Street and Number or Rural Route Number, City or Town, State) 3313 MADISON 6 Could not be determined 3 TSuicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide AT MUME STREET, HYATTSVILLE, IND
14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Huma To the Hospital 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUU176435-16473 130/05 0.0. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVEISITY Boren 0.0 31. Date filed (Month, Day, Year) 82. Registrar's Signature State 2005 Registrar

		•	For State Registrar	State of Maryla	•	artment of He <i>rtificate of D</i>			giene Reg. No.	005	16673
Ph	ysicia	an	Decedent's Name (First, Middle, La ROGER CONRA				-	2. Date of Dea Month MAY	Day 20	Λ5 <sup>Year</sup>	3. Time of Death
	Medic camin	_	4a. Facility Name (If not institution, gi			4b. City, Town, or I	Location of Death	PIXI	4c. Cour	nty of Death	10:25a M
	· ·	Ü	12092 Galena	Rd.		Massey			Ke		
	neral ector		123-18-5124	Sex 7. Age (In yrs	s. last birthday)  7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Oct 28			place (State or Foreign intry) York
land ow	Ħ		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation				T	10d. Inside City Limits
Many a-fsh	ffled	tor	MD Kent	M	assey						1 ∰ Yes 2 □ No
ith the	De no	Dire	10e. Street and Number	D 3		10f. Zip Code			10g. Citizen o		intry?
eath v	must	Funeral Director	12092 Galena	12. Was Decedent Ever in	US 13	21650	panic Origin? (Spe	acity Yas or No-	U.S.A	A • Race - Amer	ican Indian
U Z IZ IZ-UUJO filed within 72 hours after death with the Maryland Hygiene. Siter than "natural", or Items 23a or 28a-f show	other traumatic event, the Modical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ∰Yes 2 □ No 1 If Yes, Give Year or Dates: -19	955	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 21 No	, Mexican, Puerto Specify:	Rican, etc.)	Spec	Black, White	
in 72 ho	Acdical	Completed	15. Decedent's E (Specify only highest g	rade completed)	16a. Dece (Give life.	dent's Usual Occupat a kind of work done du DO NOT use retired)	tion uring most of work	ing	16b. Kind of	Business/Ir	ndustry
y ICHIC A LA butd be filed with Mental Hygiene. Brked other tha	the	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Owr	ner - Ope	erator		Lumb	er C	ompany
be file	event	Be	17. Father's Name (First, Middle, Las Gordon Ormsby				18. Mother's Name			iame)	
2 should be and Mental is marked	matic	ဥ	19a. Informant's Name/Relationship		19h Maili	ng Address (Street ar				un State Zi	in Code)
and 2 sleath an n 27 is r	r traur		Anne Ormsby	(wife)		). Box 21		lingto		-	144 p. T 144
ss 1 and of Health litem 27	r othe		20a. Method of Disposition	20b.		osition (Name of matory or other place		Date	20c. Locatio		
Dariffillor  Demit. Pages  Department of I  mportant: If its	ury o		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Spec	ify)	rumpto	on Cemet	erv 5/1	2/05	Crump	ton,	MD.
partification permit. Pages 1 and Department of Heall Important: if item 2	any in		21. Signature of uneral Service Lice	MOO	DIO IT.	to west (	CIOSS S	t. Gal	ena,	hen	L. Schaec
			23a. Fam I. Enter the disease, or conshock, or heart failure. List only	mplications that caused the de y one cause on each line.	ath. Do not en	ter the mode of dying	, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physic			Immediate Causé (Final disease or condition resulting in death)	_ d.	rary	Arter	12 D.	Soas	-		>104rs
/Med Exam			roodking in dodaily	Due to (or as a conse	equence of):	o dem					>10415
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ocuted A	transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
or ou, cate be exe	burial-	al Ex	resulting in death) Last	Due to (or as a conse	equence of);						
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	ched for use a	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[	□Ectopic pregnancy □ Other (specify)				Date of deliv Month	very Day Year
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The law requir te has been si	age 2 shou	omplete						24a. Was autop perfor 1 \( \text{Yes} \)	rmed?	b. Were aut prior to co death? 1 \( \sum \text{Yes}	opsy findings available ompletion of cause of
ian: sian:	ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Death				
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JOY Atten after deal Director	d in by the	Certification;	3 Suicide 6 Could not determine	be as Blood of Injury At	home, farm, st cify)	reet, factory, office		28f. Location (5 City or Тои	Street and Nu vn, State)	mber or Rui	ral Route Number,
a Hospita 24 hours 3 Funeraf	etely fille	edical C	29a. Certifier 1 Certifying F (Check only one) Medical Ex	hysician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	th occurred at the time ovestigation, in my opi	e, date and place, inion, death occurr	and due to the ored at the time,	cause(s) and date and plac	manner as	stated. to the cause(s)
To th within To th	сошр	Me	29b. Signature and title of ceptifier	1/	/	29c. License	_		29d. Date sig	ned (Month	, Day, Year)
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2	14		30. Name and address of person who				, C+ .	1000	MT	21621	=
0	Sta	tę	Paul Donaher  31. Date filed (Month, Day, Year)	32. Registrar's Sig		orth Mair	1 3C. G	arena,	MD.	<u> </u>	)
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			1 - For State Registrar	State of	Maryland	i / Depa <i>Cer</i>	artmen rtificate	t of Healt e of Dea	h and M	lental Hy	giene Reg. No.	005	16	674
	DI		1. Decedent's Name (First, Middle,							2. Date of De. Month	ath Day	Year		e of Death
	Physici /Medic		Janet	Elizal	eth ———		Peddio			May	4,		5 6:05	5 A M
)	Examin	er	4a. Facility Name (If not institution, g					Town, or Locati				ounty of Dea		
ш			Avalon Manor Hea  5. Social Security Number 6		Center Age (In yrs. la	et hirthday)		agersto	WN nder 24 Hrs.	8. Date of Bir		ashing		te or Foreign
	Funeral Director		217-20-7657	1□M 2XF	81	Yrs.	Months	Days Hou		(Month, Da	v Year)		ountry)	
	_		Usual Residence of Decedent		- 01					прии	10,17	_   110	, <u>, , , , , , , , , , , , , , , , , , </u>	
	nylanc how		10a. State 10b. County		10c. City,	Town or Lo	cation							e City Limits
	e Ma 3a-f s	cto	MD Washi	ngton	На	agerst								res 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip					n of What C		
	death with the Maryland ms 23a or 28a-f show rust be notified at	rai	62 Manor Dr.	12. Was Deced	ant Gran in 11 C	12.1		1740	Origin? (Sn	ecify Vas or No		J.S.A.	erican Indiar	,
	ter de	Funeral	11. Marital Status  1 □ Never Married 2 □ Married	Armed Ford	es? ⊠No				xican, Puerto	ecify Yes or No Rican, etc.)	,	Black, Wh	ite, etc.	
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215-0036	72 ho	ted	15. Decedent's (Specify only highest			16a. Deced	dent's Usua	I Occupation	most of work	ina	16b. Kind	of Busines	s/Industry	
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2	s filed within 72 hours after I Hygiene. othar than "natural", or Ite rant, I'te Medical Examina		17. Father's Name (First, Middle, La			Secr	etary		Inther's Nam	e (First, Middle,			<del></del>	
and	d be find he ad ot	Be.	Marvin Peddicord					10. 10		DeVries				
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_	and 2 sealth ar n 27 is nar trau	ľ į	Loretta Carpente	er/PR		1080	S. F	otomac	St.,	Hagerst	own,	MD 2	1740	
ē,	as 1 a of Hei litam rotha	3	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		ace of Dispo metery, crer	sition (Nar. matory or o	ne of ther place)		Date	20c. Loca	ation - City o	r Town, State	Э
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Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar 20058.		21. Signature of Funeral Service Li	censee						st Have Ave., H				
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mulications that can	used the death.	Do not ent	er the mod	e of dying, such	h as cardiac	or respiratory a	rrest,		Approxi Interval	Between
	Physician	i	Immediate Cause (Final disease or condition	Car	anom	a 1	Dano	Veas c	i met	asis			Curor	nd Death
	/Medical Examiner		resulting in death)	Due to (o	COOM ras a conseque YA I	ence of	her	n/1 aid	1.1.5				Chr	m'r.
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œ ×	death certificate e attending phys id for use as the	by Physician/Med	IF FEMALE:	23c. If yes, outco	ome of pregnan	ncv					22	d. Date of d	olivon	
Rox	eath c atten	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live bir	th 2 Fetal	death 3	Ectopic pr				23	Month	Day	Year
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2	res that igned b be deta	y P	Part II. Other significant condition	s contributing to dea	ith but not resul	lting in the u	nderlying c	ause given în P	Part I.	23e. Did t	obacco us	e contribute	to the cause	of death?
ğ	w require been sig should b							·		10	Yes 2□	No 3□F	Probably 4	<b>□</b> bnknown
Records,	rsician: The law requires that the scertificate has been signed by th director, page 2 should be delache	Completed								24a. Was auto perfo 1  Yes	rmed 🏏 📗	death:	autopsy findir completion is 2 No	ngs available of cause of
Vita		Bec	25. Was case referred to medical examiner?						Place of Deat	h (Check only				
o   	Physic this ce al dire	P	1 Yes 2 No		2.12	R/Outpatier		A CONTRACTOR OF THE PARTY OF TH	ursing Ho	ome 5 Resi			ecify)	
n N	ding P h. After funera	io i	27. Mann of Death 1 Matural 5 ☐ Pending		Day Year)	28b. Time o Injury	f 2 M	8c. Injury at Work?	2 🗆 No	28d. Describe	now injury	occurred		
Division	art sat	licat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be go Blace	of Injury - At hor	me, farm, str			20110	28f. Location (	Street and	Number or i	Rural Route I	Vu <i>mber</i> ,
≧	after Dira	Certification;	4 ☐ Homicide determin	buildin	g, etc. (Specify)	)			1	City or To	wn, State)			
	To tha Hospital or Atta within 24 hours after de To tha Funaral Diracto completely filled in by th	edical C		Physicien: To the to caminer: On the base and manne	sis of examinati									se(s)
	To the within To the comple	Me	29b. Signature and title of certifier	M				. License num			-1		nth, Day, Yea	ar)
)			•	1	: 40		1	00062	-223		5/4	1/05		
			30. Name and address of person w		of death (Item					17/6				
		ato	Vasant Datta, 31. Date filed (Month, Day, Year)		Mill S				אט 2	1740			· · · · · · · · · · · · · · · · · · ·	
	Sta Regista		MAY 0 6	3 2005	gistrar's Signati	B. 19	parke	*						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Physician April 29, Dorothy Rose Kief Plummer 19:02 p <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chester River Hospital Center Chestertown Kent 8. Date of Birth June 30, 1922 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign NY Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛛 F Months Hours 82 116-22-1019 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location Show 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23e or 28a-f show other treumetic event, the Modical Exercition in an investigate in collision as 1 X Yes 2 No Director MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 411 High Street 21620 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Spacify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 is marked o any injury or other treumeric 9 Peter Dietrich Kief Anna Kalina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Plummer/husband 411 High Street, Chestertown, Maryland 21620 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation May 3, 2005 Stevensville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P
130 Speer Road, Chestertown, Maryland 21620 21. Signature of Funeral Service Licenses Kuk of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MILURE Physician SW KZ /Medical **Examiner** MUTASTATIC CARO Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The taw requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the use IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day ò in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9□Unknown Ś been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 certificate 1 ☐ Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the hours after death unerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Medical 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the within 2 29b. Signature and title-D0060301 30. Name and address of From who completed cause of death (Item 23a) (Type, Print)

MICHAEL END MON W 124 STEAN PD 575 COPSTENT Town, WD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Month **Physician** Neil S. Reiter April 30, 4:07 P.M.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 26, 1 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F Director 61 1944 078-36-6854 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yes 2 No Silver Spring Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 11406 Monticello Avenue U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 3 Married 1 ☐ Yes 2 No Specify: White ρ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ida Fershtman Harry Reiter 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11406 Monticello Avenue, Silver Spring, Md. 20902 <u> Laura Reiter - Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 5/3/2005 Judean Mem. Gardens Olney, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Edward Sagel Funeral Direction, Inc. Donald. Cottlements 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the grath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 Month Immediate Cause (Final Physician Metastatic Brain Lesions disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 1 Month Metastatic Esophajeal Cancer Sequentially list conditions, tany leading to mineral accuse. Enter Underlying Cause (Disease or injury Due to (or as a consaquence of) Examiner The law requires that the death certificate be executed as the burial-transit 1 Year Esophajeal Cancer that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes Yes No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Na and address of person who seed cause of death (Item 23a) (Type, Print)

2005

32 Registrar's Signature

Linda M. Burrell, M. D.

31. Date filed (Month, Day,

D35996

2730 University Blvd., # 400 Wheaton, Md.

May 1, 2005

20902

			State of Maryland / Department of Health and  State AMEND#2, perMD4/29/05, DPS, MOCO  Certificate of Death			_	16677
			Registrar - Continuate of Death		Reg. N		10011
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Month		2005 <sub>rear</sub>	3. Time of Death
	/Medic		JAMES BURT REEVES	Apri		7 <del>2004</del>	7:30 P M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	ath	4	ic. County of Death	
			2001 Forest Dale Drive Silver Spring			Montgome	
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr  Months Days Hours Mir	s. 8. Date of (Month)	Birth Day, Yea	9. Birth	place (State or Foreign intry)
	Director		268.16.3655   18 M 2 F   86   Yrs.   Molitis Days   Notice   Miles		29, 1		er, Ohio
Т	p ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	shoy	<u>-</u>	2.5				1 ⊠ Yes 2 □ No
	Ba-f.	cto	Maryland Montgomery Silver Spring				
	death with the Maryland ms 23a or 28a-1 show	Director	10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Cou	intry?
	th w 238		2001 Forest Dale Drive 20903		U	J.S.A.	
	dea ems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or	r No-	14. Race - Ameri Black, White	
٥	or it		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify:			Specify: Wh	
3	ours ral',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			openy. Wil	
9500-C12	be filed within 72 hours after death with the Marylan it all thygiene.  de thygiene.  dothar than "natural", or items 23a or 28a-1 show avant. The Medical Exactines in at the nuffied at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	rorking	16b.	Kind of Business/Ir	ndustry
7	thin 19	du	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)				
Z	e filed within al Hygiene. other then " vent, I've Me	Ö	4 Years Electrical Engineer			S.Postal	Service
yland	al Hy foth vant	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)			en Sumame)	
<u>a</u>	ould be Mental arked o	0	Lloyd Reeves Etabel	11 Burt			
Mar	2 should be and Mental Is marked of raumatic ave		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street</i> and <i>Number</i> or F	Rural Route Nu	ımber, City	or Town, State, Zi	p Code)
Σ	alth 27 I		James A. Reeves/Son 611 McNeil Road, Silv	ver Spr	ing,	Maryland	20910
ē	ot He		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c.	Location - City or T	own, State
Ĕ	Page III: I		1 □ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 ☒ Other (Specify) Entombment Gate of Heaven Cemetery	/02/05	Si	lver Spri	ng,Maryland
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a one.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility				
ñ	Per Per Per Per Per Per Per Per Per Per		HINES-RINALDI FUNI	ERAL HO	ME,	INC.	« MD 2000/
			23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart is hare. List only one cause on each line.	ac or respirato	ry arrest,	april.	Approximate Interval Between
	Dhamisian		Immediate Cause (Final Matantatic Roots I Carainoma				Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Metastatic Rectal Carcinoma  Due to (or as a consequence of):				
	Examiner		Anaemia				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):				
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	al-tra	Examln	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
9	ite be executed ysician and ne burial-transit	calE					
28	leath certificate t attending physi		U.				
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	verv
ROX	atter for u	ciar	in the past 12 months?			Month	Day Year
o.	the d	iysl	1 Yes 2 No 9 Unknown				
1	res that the de signed by the s be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. [	Did tobacco	o use contribute to	the cause of death?
Records,	sign sign d be	d by		1	I □ Yes	2 No 3 □ Pro	bably 4 Unknown
Ö	w require been sign should b	Completed		240 1	46	24h Ware au	opsy findings available
ě	sician: The law certificate has t irector, page 2 s	ldu		- a	<b>Va</b> s an utopsy oerformed?	prior to c	ompletion of cause of
=		S			es 2 🖾 i		2 No
Vita	Attanding Physician: or death. actor: After this certific. by the funeral director.	Be	evaminer?	eath (Check or	nly one)		
	his I d	2				6 □Other (Spec	ify)
_	ng P	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year)  28b. Time of lnjury at Work?	28d. Descr	ibe how in	jury occurred	
0	andi eath. or: A	cati	2 Accident investigation M 1 Yes 2 No				
Division of	al or Attanding Ples after death. It Diractor: After to	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		on (Street r Town, Sta	and Number or Rui ate)	ral Route Number,
	Hospital or 24 hours afte Funaral Dir itely filled in						
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier  (Check only   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc				
	To the Hos within 24 h To the Fur completely	edi	one) and manner stated.				
	To Too	2	29b. Signature and title of certifier  29c. License number			Date signed (Month	
	5		D-27660		A	April 29,	2005
	-		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	00 5	1	100 00	0.50
_			Apana Goswami, MD, 11119 Rockville Pike , Suite#G-10	JU, Roc	kvil]	Le, MD 20	852
	Sta		31. Date filed (Month, Day, Year)  MAY 0 3 2005  32 Registrar's Signature				
	Regist	rar	MAY 0 3 2005 Brown & Spell				

		State of Maryland / Department of Health and Mental Hygiene  1- For State Registrer  Certificate of Death  Reg. No. 055 1657									16678	
			Decedent's Name (First, Middle, Last)					2 Date of Death		Vaar	3. Time of Death	
	Physici /Medio		A	lbert Conley	Robii	nson, Jr.		April 30	2005	Year	2135 P. M	
}	Examin		4a. Facility Name (If not institution, give street			4b. City, Town, or I	Location of Death		4c. County of			
			Anne Arundel Medic		16:46 1. 1	Annapol:		0.0.4.40.4	Anne A			
п	Funeral		5. Social Security Number 6. Sex 219–38–5552	7. Age (In yrs. last	t birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth July 27,	<sup>Y</sup> 1941		lace (State or Foreign	
	Director		Usual Residence of Decedent							virg	ginia	
	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "neturel", or items 23a or 28e-f show event, I'm Neufcel Everther minst be notified at		10a. State 10b. County	10c. City, T	Town or Lo	cation				1	0d. Inside City Limits	
		ctor	Md. Prince Geo	rges		Bowie					1⊠Yes 2□No	
		Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Cour	itry?	
		ra	6311 N.W. Crain Hwy				0715		USA			
36		To Be Completed by Funeral	1 ▼ Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? I ☐ Yes 2 ☑ No f Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cuban ☐ Yes 2  No		ecity Yes or No- Rican, etc.)	Black	White,		
ò	2 hou		15. Decedent's Education	on ·	16a. Deced	ent's Usual Occupa	tion	1	6b. Kind of Bus	siness/Inc	dustry	
215	within 7: ene. then "n		(Specify only highest grade co.	mpleted) College (1-4or 5+)	(Give life. L	kind of work done du DO NOT use retired)	uring most of worki	ng				
21	filed withii Hygiene. other then ent, tre M		12	,	Car	penter			Wood w		ng	
nd	be file tal Hy d oth		17. Father's Name (First, Middle, Last)	. 0 -1	C		18. Mother's Name		aiden Sumame	∍)		
<u>Y</u>				pert Conley,				ia Parks	O: T			
Maryland 21215-0036	d 2 should th and Mer 7 is marke treumatic		19a. Informant's Name/Relationship (Type, James Maldonado - I	,		g Address (Street a N.W. Cra			-			
	1 an Heal		20a. Method of Disposition			sition (Name of natory or other place			0c. Location - 0			
<u></u>	S		1 ☐ Burial 2 🖾 Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	valituii State		natory or other place .tan Crema	I	03-05 A	levandr	ria.	VΔ	
Baltimore,	コモモラ .		21. Signature of Funeral Service Licensee	TOO M		. Name and Address		all Fune			*11.	
ä	Depa Impo any ii		) Jan	Meas	65	12 N.W. C					20715	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									
			Immediate Cause (Final disease or condition Conset and Death									
			resulting in death)	Due to (or as a consequer	nce of):	0						
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172	nted insit		Sequentially list conditions, if any, leading to immediate cause. Ent at Indergring.  Cause (Disease or injury)									
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9	ng ph as th	Medi	IF FEMALE:				Section -		_			
О. Вох	The law requires that the death certificate be executed to has been signed by the attending physician and orgee 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ery Day Year	
Δ.	es that igned b be deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							use contribute to the cause of death?		
of Vital Records,	equire en sig ould b		A cute Revellar Me									
900	faw requas been 2 should	Completed						24a. Was an autopsy		ere auto	psy findings available mpletion of cause of	
E E		mo:						perform	ed? d	eath? □ Yes		
/ita	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?  1   Yes   2   Wo   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Cther: 4   Nursing Home   5   Residence   6   Other (Specify)									
of \	hys his	은										
	fing F	ion:	27. Mann. Death 28a. Date of Injury 28b. Time of Injury at 28d. Describe how injury occurred Work?  1 Natural 5 Pending (Month, Day Year) Month of Injury Mont									
Division	To the Hospital or Attending P within 24 hours after death.  To the Funerel Director: After t completely filled in by the funera	ficat	27. Mann Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 4 Homicide 4 Homicide 28a. Date of Injury - At home, farm, street, factory, office 28c. Injury at Work? 1 Yes 2 No 28b. Time of Injury - 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred							al Route Number.		
D.		erti										
		edicai	29a. Certifier 1 Certifying Physicia (Check only 2 Medicel Examiner:	n: To the best of my knowle On the basis of examination	edge, death	occurred at the time	e, date and place,	and due to the car	use(s) and mar	nner as s	tated.	
			one)	and manner stated.	n and/or in						. ,	
	To To CONT	N	29b. Signature and little of certifier		> .	29c. License			d. Date signed	(Month,	way, rear)	
	(2)	1	20 No. 10 10 10 10 10 10 10 10 10 10 10 10 10	eted eauge of death fire	20) (7:	A O O	55829		1	100		
2	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Howard Vound Manual Medical Central Annapolis MD									
	Sta Registi		MAY 0 3 2005	32. Registrar's Signatur	Grand	e						

			1 - For State Registrar		State o	f Maryla		artment of F		d Mental Hy	giene Reg. No	1111	16679	
		ě	1. Decedent's Name (First, Middle, Last)						2. Date of Death			Vose.	3. Time of Death	
	Physici /Medi		Bella					Sandler April			27,	y Year 2005	2:02 PM M	
	Examir		4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death  4c. County of Death						
			4620 N Park	Ave	Apt.	702 W		Chevy C	hase		M	ontgome	ry	
	Funeral		5. Social Security Number	6. Sex			s. last birthday)	If Under 1 Year Months Days	If Under 24 H		rth	9. Birt	hplace (State or Foreign	
	Director		350-52-3366	1 🗆	M 2 <b>∑</b> F	78	Yrs.	Months Days	Hours			927 Kal	isz, Poland	
			Usual Residence of Decedent			10- (								
	anyla shov	-	10a. State 10b. Coun	ty		106. (	City, Town or Lo	ocation					10d. Inside City Limits	
	8e-f	cto	Maryland Mont	gomei	у	Che	evy Cha						1 ☐ Yes 2 ☐ No XX	
	vith ti		10e. Street and Number								10g. Cit	tizen of What Co	ountry?	
	ath v	Funeral Director	4620 N Park A					20815				S.A.		
	er de tems	nue	11. Marital Status		Armed Fo		U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0-	<ol> <li>Race - Ame Black, Whit</li> </ol>		
36	s aft	by F	1 ☐ Never Married 2 📉 Ma 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes If Yes, Gir	2 <b>X</b> CXNo ve		1□ Yes X□ No	Specify:			Specify:	• .	
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	filled Hygi ther	Ö	17. Father's Name (First, Middle	e, Last)			1001101	7 1000		lame (First, Middle			Detence	
an	d be ental ced c	To B	Samuel Blaucw	irn						Kempner		,		
Maryland	shoul nd M mari	1	19a. Informant's Name/Relation		oe, Print)		19b. Maili	na Address (Street	and Number or	Rural Route Numi	er. City o	or Town, State, 2	Zip Code) 20815	
$\mathbf{\Sigma}$	nd 2 :		Samuel Sandle		Husbar	ad								
ē,	Hea Hea tem		20a. Method of Disposition		nusbai		Place of Dispr	sition (Name of		Date U		ocation - City or	Maryland Town, State	
<u>o</u>	ages ant of v or o		1 X Burial 2 □ Cremation		emoval from			natory or other place				•		
Baltimore,	artme orten njun		' 4 ☐ Donation 5 ☐ Other 21. Signatur			Jτ		emorial G 2. Name and Addre						
Ba	permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel; or items 23e or 28e-f show minity or other treumatic event, the Medical Examinar must be notified at ance.		b 1./ 1//	R	6					Joseph G				
			23a. Part1. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line.  5130 Wisconsin Ave N.W. Washington D.C. 20016  Approximate Interval Between											
				st only on					9, 30011 03 0010	iac or respiratory	111031,		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)  Renal Cell Carcinoma 1 year									1 year		
	Examiner	Due to (or as a consequence of):												
		-io	Sequentially list conditions,	b	b. Due to (or as a consequence of):									
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	ij	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its lead of the cause).	≺										
		Xal	resulting in death) Last  Due to (or as a consequence of):											
8760,		dical E												
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Вох		/W	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Vac 2 □ SEMs 4 □ Pregnant at time of death 5 □ Other (specify)									23d. Date of delivery		
ğ	death atte	Physician/M										Month Day Year		
O.	the cy the achec	ıγsi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown 9 ☐ Unknown											
σ.	requires been sign hould be		Part II. Other significant condi	ificant conditions contributing to death but not res				not resulting in the underlying cause given in Part I.			23a. Did tobacco		use contribute to the cause of death?	
Records,		d by								1 🗆	1 ☐ Yes 2 💢 No 3 ☐ Probably			
00		Completed	24a. Was								s an 24b. Were autopsy findings available			
Re	has ge 2	dm								- auto	psy ormed?	prior to death?	completion of cause of	
a			OF Management and American							1 Tes				
Vital	Physiclen: this certific ral director,	o Be	25. Was case referred to medic examiner?	-	ospital:			- Oth	O.C.	eath (Check only				
of	Phy ral d	1 Inpatient 2 Let/Outpatient 3 DOA 4 Nursing Home Teleside												
no	ding Ph h. After thi funeral	tion	1 X Natural 5 ☐ Pend	5 Pending investigation	(Month, Day Year) Injury			Work? M 1 ☐ Yes 2 ☐ No						
Division	Attending it death. ector: After by the fune	Certification;	3 ☐ Suicide 6 ☐ Coul	d not be	28e. Place	of Injury - At	home, farm, sti	eet, factory, office		28f. Location	Street ar	nd Number or Ru	ural Route Number.	
Ω	Dir.	erti	4 - Homicide deter	mined	buildi	ng, etc. (Spec	cify)	201, 1001019, 011100		City or To				
	spite ours neref filled		29a. Certifier 17 Certify	ing Phys	ician: To the	best of my ki	nowledge, deat	h occurred at the tir	ne, date and pla	ice, and due to the	cause(s	and manner as	stated	
	24 h	edicai	(Check only 2 Medica one)	l Exemin	er: On the b	asis of examir	nation and/or in	vestigation, in my o	pinion, death oc	curred at the time	date and	d place, and due	to the cause(s)	
	To the Hospitel or Attent within 24 hours after death to the Funerel Director: completely filled in by the	Me	29b. Signature and title of certif	ier				29c. Licens	e number		29d. Da	te signed (Mont	h, Day, Year)	
						D2335	6	April 28, 2005			005			
•	1>		30. Name and address of person	n who co	npleted caus	e of death (It	em 23a) (Type		-			,		
									(1	_ NO CO	015			
	Sta	te	Robert Blee, 31. Date filed (Month, Day, Yea	()	34 R	scons1 legistrar's Sigi	nature	#1400 Che	evy Chas	se, MD 20	-¢Τ\$	<del></del>		
	Registr		MAY 0 S	200	5 Be	EVEN 1	the special section of the section o	MELD						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® O O ST

			1- For State of Maryland / Department Certificate	t of Health and Me	ental Hygie		16680					
Ê	. SA.R.		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death					
	Physici /Medic		Johnny J. Stephens		4 22	Day Year	5:24 a <sup>M</sup>					
	Examir		4a. Fecility Name (If not institution, give street and number)  4b. City,	Town, or Location of Death		4c. County of Death						
				Washington	ı E	rince Ge	orges					
	Funeral Director		5. Social Security Number 252-76-3613 6. Sex 1	1 Year If Under 24 Hrs.  Days Hours Min.	8. Date of Birth Month Day, Xe 0 - 2 1 - 4	9. Birthp Coun Georg	lace (State or Foreign try) gia					
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits					
	Manyl 1 sho	ō	MD Prince Georges Oxon Hill				1 ☐ Yes 2√∑No					
	28a	rec	MD Prince Georges Oxon Hill  10e. Street and Number 10f. Zip	Code	10g.	Citizen of What Coun	try?					
	iges 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene.  If item 27 is marked other than 'natural', or items 23a or 28a-1 show it item 27 is marked other than 'natural', or items 23a or 28a-1 show or other traumatic avant, the Madled Exterines must be natified at	<u>=</u>	549 Wilson Bridge Drive Apt.B2 20	745	τ	Jsa						
	deat	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13 Was Decedent	tent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F	city Yes or No-	14. Race - Americ						
9	or ite	Ī	1 Never Married 2 Narried 1 Yes 2 No		ncan, etc.)	Black, White,						
003	ural',	d by	3 Widowed 4 Divorced Year or Dates:			Specify blac	:k					
15-	within 72 hours after death with the Maryland ene. then 'netural', or items 23e or 28e-1 show its Madical Executes must be nullind at	To Be Completed	15. Decedent's Education 16a. Decedent's Usua (Specify only highest grade completed) (Give kind of wor life. DO NOT us	rk done during most of working	16t	. Kind of Business/Inc	lustry					
12	within ene. than		Elementary/Secondary (0-12) College (1-4or 5+) Truck Dr	,	R	efridger	ation Co.					
Q	filed Hygid Sthar ant,		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	den Sumame)						
an	should be to the food that I is marked or numatic available.		C L Stephens	Ada Ale	xander							
Maryland 21215-0036	2 should be filled within and Mental Hygiene. is marked othar than aumatic avant, the Mis		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 270 Gets)									
	and 2 salth a n 27 is ar trai		Viola Stephens/wife 549 Wils	son Bridge								
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or othar tra once.		20a. Method of Disposition 20b. Place of Disposition (Nam cemetery, crematory or of	ne of Dather place)	ate 200	. Location - City or To	wn, State					
Ĕ	Pag ment ant: I		'4 Donation 5 Other (Specify) ResulteCt10	1		inton MD						
Salt	permit. Depart Import Import Injour		21. Signature of Edmeral Service tricensee	d Address of Facility enry Funera Street NE	1 Chane	1						
	707 8 0		900 48 My 110 420 H	Street NE	Washing	ton DC 20						
			23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	a of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death					
	Physician ' /Medical			Inal B	Leed	ine						
П	Examiner		Due to (or as a consequence of):	1	1	ð						
	uted d ansit	er	Sequentially list conditions,  Dus to for as a consequence of):  ALCOhoLic Liver Cirvhosis  Dus to for as a consequence of):									
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o,	exector and and and and and and and and and and	Exa	resulting in death) Last  Due to (or as a consequence of):									
8760,	icate be executed physician and s the burial-transit	Certification: To Be Completed by Physician/Medical	d									
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Вох	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit		23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pre		23d. Date of delive	. Date of delivery Month Day Year						
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ds,	signed d be det		Dishe Toe Mellitus	1036 givoir iir i aic i.	1 Yes							
Ö	w requir been si should I		A.		Was an 24b. Were autopsy findings available							
Vital Records,	he lav s has ge 2		nem 12		24a. Was an autopsy performed	prior to con death?	npletion of cause of					
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	s cert lirect		examiner?  1	26. Place of Death Other:		6 Other (Specify						
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ion	ktending l death. ctor: After / the funer		1 Tatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M									
Division of	I or Attendate death Diractor:	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	, office 2	8f. Location (Stree City or Town, S	t and Number or Rural	Route Number,					
	ital or A rs after al Dira led in by											
	Hosp 4 hou Funai ely fil	ledical	29a. Certifier (Check only (C	at the time, date and place, ar	nd due to the caus	e(s) and manner as sta	ited.					
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medi	and manner stated.	. License number								
	Z ½ Z Q	_	3 + 11	Th / C & (	2 C. A	Date signed (Month, I	ray, I vai)					
Λ	6	1	20 Normand address of account to complete de la 1/2 account de la	1 0 0	3 4 Hr	111 25	- 05					
1	(x)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Car Tha	A	SE- DO	1 00 70					
	Sta	tė	31. Date filed (Month, Day, Year) 2. Registrar's Signature	704 14600	1 1100	36- 9(	_ 10032					
	Registr		MAY A 2 2005 Make the America									

1 - For State Registrar

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57	Iltimore,

ı	Physic	ian	Decedent's Name (First, Middle,		Albert S	∟:11 C				2. Date of Dea	Day	Year	3. Time of Death	
	/Medi	cal	4a. Facility Name (If not institution,					r Location of	of Death	Hpril	30 40 Co	2005 unty of Death	08.52	
4	Examir	ner	Mercy Hospital			1	altim		JI BOLKII		10. 00	,		
	Funeral		• •		. Age (In yrs. last bit	rthday) If Unc	ler 1 Year	If Under		8. Date of Birth	h h	9. Birth	place (State or Foreign ntry)	
	Director		579-48-5040	1 <b>X</b> □M 2□F	69	Yrs. Month	s Days	Hours	Min.	Month, Day Dec • 26	0, 193	5 Was	h. DC	
	P.		Usual Residence of Decedent											
	arylar show	_	10a. State 10b. County		10c. City, Tow								10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	the Marylar 28a-f show	octo	Md. Prince	Georges	Bo	wie							-	
	ath with the 23a or 2	F	10e. Street and Number	D 1		10f.	Zip Code	700			•	of What Cou	ntry?	
	death with the Maryland ms 23a or 28a-f show Findst te rediffed at	Funeral Director	12311 Thompson		lent Ever in U.S.	12 Was Do		)720	gin? (Sne	city Vos or No-	US	A Race - Ameri	can Indian	
	ter de	ü	11. Marital Status  1 □ Never Married 2 ★ Married	Armed Ford	ces?	If Yes, s	pecify Cuba	an, Mexicar	n, Puerto F	cify Yes or No- Rican, etc.)	13.	Black, White		
936	urs af	b	3 ☐ Widowed 4 ☐ Divorced	d 1 □Yes 2 If Yes, Give Year or Da	tes:	1 ☐ Yes	2 <b>X</b> No	Specify:			Sp	ecity: Whi	te	
21215-0036	mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla bartment of Heatth and Mental Hygiene. sortant: if item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic svent, it a Medical Ever merimatic event, its Medical Ever merimatics.	Completed	15. Decedent's	Education	16a	. Decedent's U	sual Occup	ation	t of working	20	16b. Kind	of Business/Ir	ndustry	
215	within 7 ene. than "r	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-	4or 5+)	(Give kind of life. DO NO				'g				
	should be filed within and Mental Hygiene.  merked other than imatic svent, the Mental Country and Cou	Cou	12			Product	ion N					ov't.		
pu	be fill d oth sven	Be	17. Father's Name (First, Middle, La							(First, Middle,		mame)		
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Maryland	12 sho hand 7 is ma raum		19a. Informant's Name/Relationship	. ,, ,		3	11040		lumber or Rural Route Number, City or Town, State, Zip Code)					
	1 and Healt em 2 ther		Evelyn Maywood  20a. Method of Disposition	Still - W		Z311 11 of Disposition (/		on Ka		wie, Ma		ion - City or T		
Baltimore,	ages nt of :: If it		1 ☐ Burial 2 ☑ Cremation 3		tate cemete	ery, crematory o	r other plac							
퍨	it. Partmentant		' 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Li		Metropo	opolitan Crematory 05-03-05 Alexandria, VA.  22. Name and Address of Facility Beall Funeral Home							VA.	
Ba	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once.		161	7713	e All				bea	all Fune			1 20715	
			23a. Part1. Enter the disease, or or	omplications that ca	used the death. Do							ir y raiic	Approximate	
. II	ria-tra-		shock, or heart failure. List or Immediate Cause (Final	nly one cause on ea	ch line.	1	1	1.1	,				Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (c	or as a consequence	of):	U	11	CW	No ma	,			
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Ö	the de	Physic	1	9□ Unkno		3 0 0 0 0	Specify) _							
٥	w requires that the de been signed by the s should be detached	y P	Part II. Other significant condition	s contributing to dea	ath but not resulting	in the underlyin	g cause giv	en in Part I		23e. Did to	bacco use	contribute to	the cause of death?	
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000	w rec	iete								24a. Was a		4b. Were aut	opsy findings available	
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n of			27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of	f Injury 28b.	Time of Injury	28c. Injur	y at	2	28d. Describe h	now injury o	ccurred		
0	Attending r death. sctor: After y the fune	atic	2 ☐ Accident investiga	tion	,,	M		Yes 2	No					
Division	or Att	ţį	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289. Place	of Injury - At home, f g, etc. (Specify)	arm, street, fac	ory, office		2	28f. Location (S City or Tow	Street and N vn, State)	lumber or Rui	al Route Number,	
	ital ours af	Cel												
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Certification:	29a. Certifier 1 Certifying (Check only 2 Medical Ex	caminer: On the ba	best of my knowledg sis of examination a	je, death occurr nd/or investigat	ed at the tir ion, in my c	me, date ar pinion, dea	nd place, a ath occurre	and due to the d ed at the time, o	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)	
	thin 2 the orthe	Mec	29b. Signature and title of certifier	and mann	er stated.		29c. Licens	se number		- 4	29d. Date,s	igned (Month	Day, Year)	
	E ₹ 8			$\sim$			1110	000		-	5		05	
0	(n)		30. Name and address of person w	ho completed cause	of death (Item 23a)	(Tyne Print)	74C	4554				-1 20		
1	- (1)		1 1	chera 3	30) ST	Paul	PIV	30.11	1000	lam s	. 2	1200		
1	St	ate	31. Date filed (Month, Day, Year)		egistrar's Signature			W CIN	AINCE	~ VI (V)				
	Regist	rar	MAY 0 3 2005	Blend	and a									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

16681

State of Maryland / Department of Health and Mental Hygien® [] For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2005 Year **Physician** Robert Brooke Stabler Jr. May 1, 7:24 PM /Medical c. County of Death Frederick 4b. City, Town, or Location of Death Frederick Facility Name (If not institution, give street and number)
Frederick memorial Hospital Examiner Social Security Number 218-38-5615 8. Date of Birth October 1941 Columbia 7. Age (In yrs. last birthday) 63 Yrs. If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birtippiace (State or Foreign **Funeral** Days Hours **X**□M 2□F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at MD Frederick Middletown 1 ☐ Yes 2 X No Funeral Director 10f. Zip Code 21769 10e. Street and Number 2718 Bennies Hill Rd. 10g. Citizen of What Country? USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) supervisor c & p telephone co traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked t any injury or other traumatic eve Robert Brooke Stabler Sr. Juliet Nicholson 19b. Maijing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2718 Bennies Hill Rd., Middletown, MD 21769 19a Informant's Name/Relationship (Type, Print)
Glenda Stabler (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of er place. 1 Burial 2 Cremation 3 Removal from State Frederick Crematory 5/3/05 Frederick, MD \* 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup>Donald B. Fallompson Funeral Home 31 E. Main St., Middletown, MD 21. Signature of Fineral service Lice 21769 23a Part 1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiovase dar Disease Physician /Medical Examiner pertensio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Cara Examiner Due to (or a / a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 certificate 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 3 DOA After this Manner of Death
Natural
Coldent 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 T Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roh Year) 31. Date filed (Month, 32( R gistrar's Signature State 0 4 Registrar

			For State Registrar	i icase	State of Ma	aryland / D		of Health	n and Me	ental Hy		•	16683	)
	Physici		1. Decedent's Name		Scott, Si	r.				2. Date of Dea		Year OS	3. Time of Death	— И
	/Medic Examin				e street and number)		4b. City, T	own, or Location	on of Death	03		County of Death	W1.12	_
	E Addition		SACRED	HEART !	HOSPITAL		C	UMBER	LAND		4	ILEG A	NY	
	Funeral Director		5. Social Security Nu 212-24		ex 7. Ag M 2□F	75	hday) If Under 1 Months	Year If Und Days Hour	ter 24 Hrs. s Min.	8. Date of Birt (Month, Da Oct. 29	h y, Year) 192	9. Birthp Cour 9 Mary	lace (State or Foreignty) Land	רזו
	P _		Usual Residence of			40- Ob. 7								_
	Maryla -f show	tor	MD	10b. County Allega	ny	10c. City, Town						'	0d. Inside City Limits 1 Tyes 2 No	
	h with the 23a or 28a	al Director	10e. Street and Num 12016	Kite Av	e.		10f. Zip (	ode 1502			10g. Citiz	en of What Cour	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumatic event, I'le Mudical Exarterer trius Le multibul at ance.	by Funeral	11. Marital Status  1 Never Marrie 3 Widowed		12. Was Decedent Armed Forces? 15 Yes 2 1 If Yes, Give Year or Dates:		13. Was Decede If Yes, speci			cify Yes or No lican, etc.)		4. Race - Americ Black, White, Specify: W		
21215-0036	thin 72 ho e. an "natur Modical	Completed	(Special Special 15. Decedent's Ed fy only highest grandary (0-12)	ducation ade completed) College (1-4or 5	16a.	Decedent's Usual (Give kind of work life. DO NOT use	done during m retired)	nost of workin	g		d of Business/In	•		
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Maryland	ould be fil Mental H arked ott	To Be	17. Father's Name (Percy	H. Scot						(First, Middle,				
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	1 and Health em 27 ther t		Irene 20a. Method of Disp		Spous		12016 K			umber		ation - City or To	21502	
Baltimore,	ages nt of I t: If ite		1 ☑ Burial 2 🖸	Cremation 3	Removal from State	Vale	Disposition (Namy, crematory or oti	ner place)					ummit, N	
Ħ	artme ortani injury		<ul> <li>4 ☐ Donation</li> <li>21. Signature of Fur</li> </ul>			\ \ \ \ \		Address of Fa	-10a -					1L
B	Depa Impo any in			oualo	-811	lan	1302 N	ationa	на 1 Hwy	., La	Vale	al Ser , MD	vice PA 21502	
760, <	Physician /Medical Examiner buriar-transit sthe puriar-transit	icai Examiner	shock, or hear Immediate Cause (I disease or condition resulting in death)  Sequentially list con if any, leading to imcause. Enter Under Cause (Disease or i that initiated events resulting in death) L	Final  ditions, mediate lying njury	Due to (or as  b		RENAL					NOMA	Approximate Interval Between Onset and Death	2
P.O. Box 68	The law requires that the death certificate to be been signed by the attending phy age 2 should be detached for use as the	Physiclan/Med	1F FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pre 5 □ Other (spe				23	3d. Date of delive	ery Day Year	
	w requires that been signed b should be deta	by	Part II. Other signifi	cant conditions of	contributing to death b	ut not resulting in	the underlying ca	use given in Pa	urt I.		obacco us	,	ne cause of death?	٦
Division of Vital Records,	The law rec sete has bee page 2 shou	Completed									rmed?	24b. Were auto prior to co death? 1 \( \sum \text{Yes}	psy findings available mpletion of cause of	9
ta		BeC	25. Was case referre	ed to medical				26. Pl	ace of Death	1 Yes (Check only o	ne)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2,23110	_
× ×	Physician: this certific ral director.	To	1 Yes 2 21		Hospital: 1 Inpatie	ent 2 ER/Out			Nursing Hom	e 5 🗆 Resid	dence 6	□Other (Specif	y)	
ion	ding After tune	ation:	27. Manner of Death 1 ☑Natural 2 ☐ Accident	5 Pending investigation			ime of 28 njury M	c. Injury at Work? 1  Yes 2		8d. Describe i	now injury	occurred		
Divis	al or Attended the destriction of the ctor:	Certification:	3 🗍 Suicide 4 🗍 Homicide	6 Could not b determined	286. Place of Inj	ury - At home, fai c. (Specify)	m, street, factory,	office	2	8f. Location (5 City or Tox		Number or Rura	il Route Number,	Ī
	To the Hospital or At within 24 hours etter of To the Funerel Direct completely filled in by	edicai C	29a. Certifier (Check only one)	Certifying Ph Medical Exer	sysicien: To the best niner: On the basis o and manner st	f examination and	, death occurred a Vor investigation,	t the time, date in my opinion, d	and place, ar death occurre	nd due to the d	cause(s) a date and p	ind manner as s place, and due to	tated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and	of certifier	Ma		29c.	License numbe	er		29d. Date	signed (Month,	Day, Year)	
)			1 A	1	- IVVI			2337			Mary	19,2	.005	
	1211		DR Gram	err. Zan	completed cause of c	leath (Item 23a) (	Type, Print)	Cumb	erlan					
	Sta Registr		31. Date filed (Monta	MAY 76	32. gratr	ar's Signature	_							

State of Maryland / Department of Health and Mental Hygiene

			State of Mary		Certifica			wientai i i	Reg. No.	15	16681
		1. Decedent's Name (First, Middle, Le	st)					2. Dete of D	eath Day	Year	3. Time of Death
1.00	Physician /Medical	Carolyn Sue	Sawyer	s				May			8:08 p m
	Examiner	4a Fecility Name (If not institution, giv					4b. City, Town, or			y of Death	
		211 Central Av					Western		Alle	gany	
	Funeral Director	232-74-4250	I M ONE	yrs. last birth 57 Yr	Month	der 1 Year ns Days		8. Date of B (Month, D Jan 1	irth Ney, Year) 3,1948	9. Birthr Cour WV	otace (State or Foreign ntry)
	and	Usuat Residence of Decedent  10a. State 10b. County	100	. City, Town	or Location					1	10d. Inside City Limits
	Maryl 4 sho	MD Allega	nsz W	ester	nnor	+					1 Yes 2 □ No
	rec	10e. Street and Number	illy vv	ester		Zip Code			10g. Citizen of	What Cour	ntry?
	h with	211 Central Av	enue			2156	2		U.S.A		
S	within 72 hours after death with the Maryland within 72 hours after death with the Maryland end.  The Marical Examiner must be notified at the Marical Examiner must be notified at the Marical Examiner must be notified at the Marical Examiner must be notified at the Marical Examiner must be notified at the Marical Examiner must be notified at the Marical Examiner must be notified at the Marical Examiner must be notified at the Marical Examiner must be not the	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	in U,S.		cedent of I pecify Cub	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)		ce - Americ ck, White, fy: Wh:	etc.
21215,0020	hours and hours at Exact	3 ☐ Widowed 4 ☐ Divorced	Year or Detes:	10- 0							
Ī	ed within 72 ho ygjene. or than "nature it, the Medical!	15. Decedent's Ed (Specify onfy highest gre	ede completed)	16a. D	ecedent's U Give kind of t ife. DO NOT	suai Occu work done Luse retire	pation during most of wo ed)	rking	16b. Kind of E	ousiness/in	dustry
3	with with the comp	Elementery/Secondary (0-12)	Cotlege (1-4or 5+)		Beau				Beau	+ v <1	hon
Ì	ent, ent,	17. Father's Name (First, Middle, Last)	)		beau	() <u>1</u> ( <u>,</u> 1		me (First, Middl	e, Maiden Suma		.:0,0
2	uld be filed within whental Hygiene. rked other than ritic event, the M	Bernard Davis					Sara	h Penn	ington		
T C C C C C C C C C C C C C C C C C C C	VICILY FIGURE A. 12 Should be filed with and Mental Hygier its marked other traumatic event, the To Be Co.	19a. Informant's Name/Relationship (	Type, Print)	19b. N	Maiting Addre	ess (Street	t and Number or R	ural Route Num	ber, City or Towr	, State, Zip	Code)
	- 5 ± 2 :	Thomas L. Sawy					Ave., We	estern	port,MI	215	·62 ·
Blue Int	permit. Pages 1 and Department of Healt Important: if Item 2; any Injury or other pince.	20a. Method of Disposition  1 □ Burial 2 ▼Cremation 3 □ 4 □ Donation 5 □ Other (Specify	1	b. Place of D cometery, Scarp	ciematory o elli	cren	matory5				
144	Demit. Departimonts any injury	21. Signature of Funeral Service Licer	hehim	01)	22. Name Mark	and Addre	ess of Facility I Funera neral S	l Home	e van Wi	267	22.6
62 1		23a. Pert1. Enter the disease, or com- shock, or heart failure. List only	plications hat caused the d	leath. Do no	t enter the m	ode ol dyi	ng, such as cardia	c or respiratory	arrest,	201	Approximate
96	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition	a. METAST								Interval Between Onset and Death
6		resulting in death)	Due t	to (or as a co	nsequence o	of):				_	
23	ficate be executed physician and is the burial-transit edical Exeminer	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue t	o (or as a co	nsequence o	of):	31			 	
C 09289 xc	÷ 0100 =	Cause (Disease or Injury that initiated events resulting in death) Last	Due to	o (or as a cor	nsequence o	of):					
ă	death cert attendin d for use	Part II. Other significant conditions or	ontributing to death but not	resulting in t	he underlying	a causa ai	ven in Part I	23h Die	I tohacco use co	ontribute to	o the cause of death?
0 0 80	at the death cer by the attendir etached for use	Takin. Other algimount conditions of	ominating to death but not	resuming in th	ne undenym	g cause gr	VOITIIT AICI.		Yes 2/1 No		bably 4 Unknown
U	iras that signed t d be det										
Division of Vital Records	The law require rate has been sing page 2 should I							24a. We	s en autopsy formed?	av	ere autopsy findings vailable prior to empletion of cause death?
<u> </u>	The is rate he page							10	ON (XE eaY)	1[	☐Yes 2년No
<u>-</u>	ician: The certificata rector, pa	25. Was case referred to medical examiner?					26. Place of De				
<b>-</b>	Physicia this cert ral direct	1 ☐ Yes 2 🎇 No		2 ER/Outp		DOA OI	her: 4 Nursing h				ý)
2	Affing P. Affect funeration:	27. Menner of Death 1 ☑Naturel 5 ☐ Pending	28a. Date of Injury (Month, Dey Year	r) 28b. Tim Inju	ıry	28c. Inju Wo		28d. Describe	how injury occu	rred	
	tending last.  tor: After the fune	2 Accident investigation 3 Suicide 6 Could not be	a -	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	M		Yes 2 No	OOA Loopting	Chroni and Alven	har as Dus	al Davida Alumbay
<u> </u>	after d in by	4 ☐ Homicide determined	28e. Plece of Injury - A building, etc. (Sp.	ecify)	n, street, tact	огу, опісе		28f. Location City or To	own, Stete)	ber or Hurz	al Route Number,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		ysician: To the best of my sainer: On the basis of examend manner steted.								
_	Vithin Vithin To th comp	29b. Signature and title of certifier	20/	_			se number		29d. Date sign		-
			IYV			D002	23371		May 10	, 20	05
	4	30. Name and address of person who of Dr. Qamar U. Za	aman, M.D.			Ave.	,Cumber	land,	Maryla	nd 2	1502
	State Registrar	31. Dete filed (May 144), 1 6 201	Registrar's Si								

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Man		artment of <i>rtificate of</i>			giene (	5	166	85
	Dhii		1. Decedent's Name (First, Middle, Last)					2. Date of De. Month		Year	3. Time of	f Death
	Physici /Medio		ESTHER W. THIBE	AULT				April	27 20	05	12:45	A M
	Examir	er,	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,			4c. County			
			Fox Chase Nursing 5. Social Security Number 6. Sex		a use fast high day	Silv If Under 1 Year	er Spri			tgom		
L	Funeral Director		579-44-8581 <sup>1□</sup>		01 Yrs.	Months Days		Min. 8. Date of Bird (Month, Da July 24	y, Year)	Cou	place (State o intry) nesota	_
	land		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or L	ocation					10d. Inside Ci	ity Limits
	Ash fed	tor	Maryland Montgome	rv	Silver	Spring						2□No
	r 288	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of N	What Cou	intry?	
	th wit		9509 Midwood Road			20910			U.S.A.			
	ems ems	Funeral	11. Marital Status 1	Was Decedent Eve Armed Forces?		Was Decedent of If Yes, specify Cul	Hispanic Origin	? (Specify Yes or No	- 14. Rac	e - Ameri k, White	ican Indian,	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Hygiene. id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event. The Madical Examinat must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1☐ Yes 2⊠ No		33.10 / 1132.1, 313.7		Wh		
2	72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occu	pation	working	16b. Kind of B	ısiness/lr	ndustry	
2	Athin 196.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	/ife.	DO NOT use retire	9d)	WORKING				
2	iled v tygie ther t	Co	12th 17. Father's Name (First, Middle, Last)		Nur	sing Aide		None (Sint Middle	Health		Servi	ces
and	permit. Pages 1 and 2 should be fill Department of Health and Mental HI Important: If Item 27 is marked oth any injury or other traumatic event once.	o Be	Andrew Petersen				Mar:	Name (First, Middle, ie Nielse		10)		
<u>Z</u>	shoul nd Me mark mati	2	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Maili	ng Address (Stree		r Rural Route Numbe		State. Zi	n Code)	
Š	alth a 27 is		Esther B. Weber/D	aughter				Silver Spr				
ē,	of Heg		20a. Method of Disposition	- :	20b. Place of Dispo cemetery, cre			Date	20c. Location -			
Ē	Page nent c		1 Burial 2 □ Cremation 3 □ Re  `4 □ Donation 5 □ Other (Specify)	emoval from State				/30/2005	laldorf.	Mar	vland	
Baltimore,	spartr sports ny inji		21. Signature of Funeral Service Licensa	e \ _				NERAL HOME		11012	Juna	
1)	2012		Navey A. V.	acut.	. 11	1800 New	Hampsh	ire Ave, S	ilver S	prin	g,MD 20	3904
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the e cause on each line.	death. Do not en	ter the mode of dy	ing, such as car	rdiac or respiratory ar	rest,		Approximate Interval Bety	ween
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	Congestiv	e Heart	Failure					Onset and D	
	/Medical Examiner		resulting in dealth)	Due to (or as a co	onsequence of):							
		0	Sequentially list conditions, if any leading to immediate	Due to (or as a co	onsequence of):							
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Oblishad or in Jury that initiated events c.	( 2- 2- 2- 2- 2- 2- 2- 2- 2- 2- 2- 2- 2								
n n	exection and ital-tra	Еха	resulting in death) Last	Due to (or as a co	onsequence of):							
2/60	certificate be executed rding physician and use as the burial-transit	dlcal	d									
٥		Φ 1	IF FEMALE:									
X Q Q	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of p		Jectopic pregnanc	ev			e of deliv	,	
	0 0	Physician/M	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown	e of death 5[	Other (specify)	<u></u>		Mo	ntn	Day Y	Year
ī	that the side by detac	Ph	Part II. Other significant conditions cont	ributing to death but n	ot resulting in the u	nderlying cause of	ven in Part I	23e Did to	bacco use cont	ribute to t	he cause of d	looth?
Records,	w requires that the sbeen signed by the should be detached	ed by	Hypertension						es 2□No			
000	aw as b	ompleted	Urinary Tract In	nfection				24a. Was	an 24b. \	Vere auto	opsy findings a	available
	. 60 0	Com						— autop perfor 1 ☐ Yes	rmed?	death?		ause or
Vital	ysician: Th	Be	25. Was case referred to medical examiner?				26. Place of	Death Check onl of				
5	Physic this c	P,	1 ☐ Yes 2X No	ospital:	2 ER/Outpatier	IL SU DOA		ng Home 5 ☐ Resid	lence 6 □Oth	er (Specia	fy)	
<u></u>	ding F h. After funera	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	aar) 28b. Time o	Wo		28d. Describe h	ow injury occurr	ed		
DIVISION	ottendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Isium	At home form at		]Yes 2□No	29f Lagation /6	Strant and Mumb	O	-/	
2	spital or A ours after neral Direc filled in by	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)	eet, factory, office		City or Tow	Street and Numb m, State)	er or Hura	ai Houte Numi	ber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 X Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of mer: On the basis of exa and manner stated	amination and/or in	n occurred at the treestigation, in my	ime, date and p opinion, death o	lace, and due to the occurred at the time, o	cause(s) and ma date and place,	nner as s and due t	stated. o the cause(s)	)
	To the To the comp	Ž	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed	d (Month,	Day, Year)	
1	4		Shopping.			D-2	8656		April 2	8, 2	005	
	0		30. Name and address of person who com	•								
			Ravi Passi, MD, 86				04-B, S	ilver Spr	ing, MD	209	10	
	Star Registra	-	31. Date filed (Month, Day, Year) MAY 0 3 2005	32. Registrar's	gnature							

State of Maryland / Department of Health and Mental Hygiene 16686 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 29, **Physician** 2005 TRUMAN LEONA MARIE 02:24A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 7541 Knoll Arces Road Hanover 1 Year If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months 1□M 25 F 43 Yrs. 8-6-61 Director Colorado 098-58-2175 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at xxyes 2 □ No Director MD. Anne Arundel Hanover 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21076 7541 Knoll Arces Road U.S.A. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? hours after 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married SpecifyBlack Maryland 21215-0036 1 Yes 2 X No Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education within 72 (Specify only highest grade completed) and Mental Hygiene, ie marked other than College (1-4or 5+) Elementary/Secondary (0-12) Unemployed N/A 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Depertment of Health and Mental Important: If Item 27 1e marked any Injury or other traumatic events. Alice Green Lawrence Truman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7541 Knoll Arces Rd. Hanover, Md. 21076 Alice Lyons/Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/4/05 Riverdale, Md. Riverdale Park 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 21. Signature of Fineral Service Licensee 814 - Upshur Street, N.W. enter the mode of dying, such as cardiac or respiratory arrest, Ent- the disease, or complications that caused the death. Do not ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death arcinoma diate Cause (Final manths **Physician** di ase or condition sulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dist to (or as a consequence of) Examiner certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. attending physicien Physician/Medical the as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No o 9 Unknown 9 Unknown ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo this ospital or Attending Physical Process after death.

Inneral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00057985 April 29, 2005 arac 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sara Horton, M.D. 888 Bestgate Rd. S-211 Annapolis, Md. 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 0 3 2005 Registrar

Noah Tabeka

05-032 NJM	57	1- State Unpend Item 2	State of Maryla				-		_	16687
				Ce Ce	rtificate of	Death				
Physi	ician dical	Decedent's Name (First, Middle, Las     Noah	Tabe	ka			2. Date of Dea Month Mav	Day	Year 2005	3. Time of Death
Exam		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. Co	ounty of Death	
		Shady Grove Adver			Rockvi]			Mo	ntgome	Cy.
Funera Directo		5. Social Security Number 6. Sr 213–45–2824	9x 7. Age (In yrs	s. last birthday, 9 Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da June 26	1995	9. Birthp Cour Mary	lace (State or Foreign Land
pg &		Usual Residence of Decedent  10a. State 10b. County	100.0	City, Town or L	ocation		<del></del>		1	0d. Inside City Limits
e Maryla le-f shor	ctor	Maryland Montgom		_	boow					1 ☐ Yes 2 ☐ No
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. d other than "naturel", or Itams 23a or 28e-1 show evant, the Medical Examinat must be notified at	al Director	10e. Street and Number 16639 Killdeer Dr	rive		10f. Zip Code	20855		10g. Citizer Unite	ed Stat	ntry? .es
death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No	- 14.	Race - Americ Black, White,	
s after ', or Ita	by Fu	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:	mean, etc./		ecify:	White
Z I 3-UU30 thin 72 hours aff e. an "naturel", or Medical Exam	ted b	15. Decedent's Ec	lucation	16a. Dece	edent's Usual Occup	pation	ina	16b. Kind	of Business/In-	dustry
within within than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire udent	during most of worki d)	9	edu	cation	
Ore, Maryland Z. pes 1 and 2 should be filed w of Health and Mental Hygies If item 27 Is marked other ti or other treumatic event, Ib.	To Be Co	17. Father's Name (First, Middle, Last) Ronny	Tabeka			18. Mother's Name Hannah		Maiden Su ashli		
Mary ad 2 shou th and M 27 is mar r troumati		19a. Informant's Name/Relationship ( Hannah Tabeka –mo		19b. Mail 1663	ing Address (Street Killdee	and Number or Rura r Drive D	al Route Number	or, City or To Mary	own, State, Zio Land 20	Code) 1855
Saltimore, Dermit, Pages 1 ar Department of Hea mportant: If item any Injury or othe		20a. Method of Disposition  1 A Burial 2 Cremation 3   4 Donation 5 Other (Specification)	Removal from State	Place of Disp cemetery, cre arden o	osition (Name of ematory or other pla f Remembr	ance 5/13	/2005		tion - City or To sburg,	own, State Maryland
barrimor permit. Pages ' Department of the Important: If ite eny Injury or ot	OUC9.	21: Signature of Funeral Service Licer		DX 4	onald wide	Borgwardt r Mill Ro	Funera ad Belt	l Home	e, PA	land20705
Physicia /Medica Examine	al	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	rrest,		Approximate Interval Between Onset and Death					
D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	equence of):						
BOX b8/bU, eath certificate be executed attending physician and for use as the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
bb/ ificate t g physical as the t	edical		_ d							
. 0 00	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic pregnanc □ Other (specify) _	у		230	d. Date of delive Month	ery Day Year
ecords, P.O. law requires that the as been signed by th	by Ph	Part II. Other significant conditions of	ontributing to death but not r	esulting in the	underlying cause gr	ven in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
w require been significations	ted	Obesity					1 🗆 '	Yes 2 1	No 3 ☐ Prob	pably 4 □Unknown
The The page	Completed								prior to co death?	psy findings available mpletion of cause of
OT VITAI F Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0#	26. Place of Deat			, ,	
ohys this	P.	1X Yes 2 □ No 27. Manner of Death	1 ☐ Inpatient 2	XER/Outpatie	ant 3 DOA	4 Nursing no	me 5 Resi			(y)
	ton	1 X Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wo	rk? ]Yes 2 □ No	Edd. Describe	non injury c	,000	
DIVISION I or Attending after death. Director: After	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e One Diese of Leiner As	home, farm, s			28f. Location (. City or To		Number or Rura	al Route Number,
Hospite 4 hours Funeral ely filled	Medical Co		ysician: To the best of my k niner: On the basis of exami and manner stated.							
To the h within 24 To the f complet	Me	29b. Signature and title of certifier	$\wedge$		29c. Licen:			29d. Date s	signed (Month,	Day, Year)
		1 Q prb	ell)			CME 		May	, 11, 2	2005
		30. Name and address of person who	completed cause of death (If	tem 23a) (Type	111 Pen	n Street	Baltim	ore, l	Marylan	d 21201
	State	31. Date filed (Month, Dan Year)	2005 32. Fagistrar's Sig		hack ?					

Registrar

			1 - For State Registrar			d / Depa		Health	and Menta	al Hygie	ene 2 0 0 5	16688
			1. Decedent's Name (First, Mid	dle, Last)			19			te of Death	Day Yes	3. Time of Death
	Physicia /Medic		David	Lee	Alston				5	onth 14	2005 Year	9:30p. M
	Examin		4a. Facility Name (If not instituti	on, give street and num	ber)		4b. City, Town	, or Location	of Death		4c. County of Death	
н			5937 Leith W	alk			Ba.	ltimor	φ.		N/A	
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. la	ast birthday)	If Under 1 Year Months Day	ar If Unde	r 24 Hrs. 8 Da	ite of Birth onth, Day, Y		nlace (State or Foreign
	Director		219-40-7094	1 <b>∑</b> M 2□ F	62	Yrs.	WOTIGHS Day	7 710013	10		1942 M	
	p >		Usual Residence of Decedent  10a. State 10b. Coun	<b>5.</b>	10a Cibe	, Town or Lo	- anti					
	anyla shon	_		N/A		Baltim					1	0d. Inside City Limits 1   Yes 2   No
	8e-1	ctc		,								
	with th	Director	10e. Street and Number	t.7_ 7.1_			10f. Zip Code			100	g. Citizen of What Cour	ntry?
	ath v		5937 Leith					1239			USA	
	er de	Funeral	11. Marital Status	12. Was Deced	es?	S. 13.	Was Decedent of If Yes, specify Co	f Hispanic O uban, Mexica	rigin? (Specify Y an, Puerto Rican,	es or No- etc.)	14. Race - Americ Black, White,	
36	s aft	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☑ Divorce	If Yes Give	2 ∐ No		1□Yes 2□N	lo Specify	<i>/</i> :		Specify:	. 1
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or Items 23e or 28e-f show event, the Medical Eraminar must be notified at	pe	<b></b>	ent's Education	.65.	162 Dece	dent's Usuaf Occ	unation		16	BLa  Bb. Kind of Business/In	ack
75	n 72 "na redic	Completed	(Specify onfy high	nest grade completed)		(Give	kind of work dor DO NOT use reti	ne during mo ired)	st of working		D. Kind of Businessynt	dustry
12	with Bne. thar	E C	Efementary/Secondary (0-12	College (1-	4or 5+)	Dri		,			M.T.A.	
0	filed Hygi Sther ent, I		17. Father's Name (First, Middl					18. Moth	ner's Name (First			
<u>a</u>	Mental Arked c	То Ве	Willie	Alsto	n				Mildred		Brown	
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other treumatic	-	19a. Informant's Name/Relatio	nship (Type, Print)		19b. Mailii	ng Address (Stre			te Number, (	City or Town, State, Zip	Code)
$\tilde{\mathbf{z}}$	and 2 Balth a n 27 ls		Dawn Alston-d	aughter		5937	Leith W	Walk B	altimore	e, MD	21239	
ē,	s 1 and strength Health item 27 other tr		20a. Method of Disposition		20b. PI		sition (Name of natory or other p		Date		Oc. Location - City or To	own, State
9	Page ent o ent o rt: If		1 XBuriaf 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other		late		Forest		5/23/200	)5 0	wings Mil	ls MD
Baltimore,	글로벌를 .		21. Signature of Funeral Service				2. Name and Add		lity			
ä	Depa Impo any ii		> & lo	dus U	Oan	الع	ם ומנו	NT			RAL HOME-EA	
	Oli-i		23a. Part1. Enter the disease, shock, or heart failure. L' fmmediate Cause (Final	or complications that ca st only one cause on ea	ch line.	. Do not ent	er the mode of d	ying, such a	s cardiac or resp	iratory arres	more, MD	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (o	r as a consequ	my oc	av digl	- 1^	Pareti	oh		
	Examiner			2001010	(							
	التتم	e	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying	b. Due to (o	r as a consequ	ience of):	<u>-</u>					
	uted d ansit	Examine	Cause (Disease or injury that initiated events	1								
Ć	execuna and rial-tr	Exa	resulting in death) Last	c. Due to (o	r as a consequ	ence of):						
68760	death certificate be executed e attending physician and id for use as the burial-transit	cai		d								
	leath certifical attending phy I for use as th										1.	
Вох	h cer andin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnar th 2 DFetal		DEctopic pregnar	201			23d. Date of delive	ery
	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	nt at time of de		Other (specify)				Month	Day Year
P.0	by the a	hys	9 🗆 Unknown	9∐ Unknov	wn							
S,	The law requires that the ate has been signed by th bage 2 should be detache	ру Р	Part II. Other significant cond	itions contributing to dea	ath but not resu	ilting in the u	nderlying cause	given in Part	1. 2	3e. Did toba	cco use contribute to the	ne cause of death?
ğ	w require been sig should t									1 🗆 Yes	2 No 3 □ Prob	ably 4 Unknown
Record	as been 2 shoul	Completed							2	4a. Was an autopsy		psy findings available inpletion of cause of
æ	The lavate has	E							1	performe	ed? death? No 1 ☐ Yes	2□No
Vital		O	25. Was case referred to medi	cal				26. Plac	e of Death (Che			
>	S S	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 □ In	patient 2 🗆 l	ER/Outpatier	nt 3 DOA	Other: 4 N	lursing Home 5	Residen	ce 6 □Other (Specif	y)
ı of	g Ph ter th		27. Manner of Death	28a. Date of	Injury , Day Year)	28b. Time o	f 28c. In	jury at	28d. D	escribe how	infury occurred	
Division	Attending Indeath.  ector: After by the funer	atio	Z / tooldont	stigation	, 22) . 02.7	injury		☐Yes 2☐	□No			
Vis	tel or Attendits after death.  July Director; A sid in by the fu	tific	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 286. Place	of Injury - At ho g, etc. (Specify	me, farm, st	reet, factory, offic	<b>(8</b>		ocation (Stre	et and Number or Rura State)	al Route Number,
Ö	s afte	Certification:			gi oto. (e,poon)					,		
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th		29a. Certifier 1 Certifier (Check only Medic	ying Physician: To the I al Examiner: On the ba	pest of my know	wledge, deat	h occurred at the	time, date a	and place, and du	e to the cau	ise(s) and manner as s	tated.
	the H hin 24 the F nplete	Medical	one)	and mann	er stated.		vestigation, in in	y opinion, do	atii occuiiod at t			
	To t To t	Σ	29b. Signature and title of certi	1 6/1			29c. Lice	nse number		290	d. Date signed (Month,	
	. 1		/ - ( do	nf el.	3	and the same of th		130	194/		5/16/05	
1	1/1		30. Name and address of person	on who completed cause	of death (Item	23а) (Туре,	Print)					
V	1		la	id Ei	enher							
	Sta		31. Date filed (Month, Day, Ye.	1 8 2005 32 Re	strar's Signal							
	Registi	rar	ווחווי	+ 0 ZUU5	Police	K	boots 5					

DHMH 17 Rev 1/2001

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			•	ype or Print in Bia			•	_	
			1 - State Amend Item 2	State of Maryland 26 per Verb.,G	Departmen 843 05/18 Certificati	t of Health and N 05flbbeath	Mental Hygien Reg. N	2005	16689
<b>)</b>	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     CO     A. Facility Name (If not institution, give st	Ader		Town, or Location of Death	April 2	4 2005 c. County of Death	3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex 010 - 10 - 9606  Usual Residence of Decedent	M 2 F O I O I O I O I O I O I O I O I O I O	birthday) If Under Months Yrs.	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Pay, Yea APYI 15	1904 E	GEOVACE Diace (State or Folder ptry)
	Maryland a-f show	tor	10a. State 10b. County MD Prince Ge		own or Location Ltchellvil	le			10d. Inside City Limits 1 ☐ Yes 2√ No
	th with the 23a or 28	ai Director	10e Street and Number 10450 Lottsford Ro	ad #204	10f. Zip	Code 20716	10g. (	Citizen of What Cour USA	ntry?
036	72 hours after death with the Maryland Insturel; or Items 23s or 28s-f show cites Esseries must be notified at	by Funerai	11. Marital Status 1 1 🗓 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗀 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Deced If Yes, spec	dent of Hispanic Origin? (Sporty Cuban, Mexican, Puerto 2 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify: W	
Maryland 21215-0036	within ene. then	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		6a. Decedent's Usua (Give kind of wo life. DO NOT us	rk done during most of wor	king	Kind of Business/In	·
ylandz	be filed ital Hyg id othe event,	To Be Co	17. Father's Name (First, Middle, Last) Alphonso L. Ader			Elsie	ne (First, Middle, Maid Gildersle	en Sumame) eve	
	1 and 2 s Health ar In 27 is ther trau		19a. Informant's Name/Relationship (Type COllington Episcopa 20a. Method of Disposition	20b. Plac		ttford Road ne of there place)	Mitchellvi		20716
Baltimore,	permit. Pages Department of I Important: If its any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☑ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License  ROD2 1.1	emoval from State		d Address of Facility Anatomy Board	d 655 W. Ba	altimore :	Street
	Physician /Medical Examiner		23a. Part1. Et ter the disease, or complic shock, of heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	tions the caused the death. e cause on each line.	Do not enter the mod	ore, MD 2120 Be of dying, such as cardiac	or respiratory arrest,	, is b	Approximate Interval Between Onset and Death
,160,	be executed ician and burial-transit	ical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer					
P.O. Box 68	The law requires that the death certificate ate has been signed by the attending physogge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetel de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pi			23d. Date of deliv Month	ery Day Year
	juires that the de n signed by the a lid be detached f	by	Part II. Other significant conditions con	,	ng in the underlying o	ause given in Part I.		ouse contribute to t	the cause of death?
Division of Vital Records,		Completed	Defreson				24a. Was an autopsy performed'	prior to co	opsy findings available ompletion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	e anital:			th (Check only one)		
1	Physi this o	2	T Tes 2210	ospital:		DA 4 Nursing H	The second secon	6 ☐ Other (Speci	fy)
ion	Attending Physician: r death. ector: After this certifics by the funeral director, I	ation:	27. Manner of Death  1 PNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	3b. Time of 2 Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	Describe how in	jury occurred	
Divis	i di te	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom- building, etc. (Specify)			28f. Location (Street City or Town, St.	ate)	
	Hose 24 ho Fune Fune	ledical		ician: To the best of my knowle er: On the basis of examination and manner stated.					
1	To the Hospital within 24 hours a To the Funeral i completely filled	Me	29b. Signature and title of certifier	F. 1		c. License number	29d. I	Date signed (Month,	Day, Year)
			30. Name and address of person who co	mpleted cause of death (Item 2		Jender P	1. Lenta	m, md	20706
ž.	St: Regist	ate	31. Date filed (Month, Day, Year) MAY 1 8 2005	32. Registrar's Signatur	e alla e				

			For State Registrar	State of Mary		artment of H			giene Reg. No.	05	669	0
	Physicia		Decedent's Name (First, Middle,	111	Λ	1 1 =		2. Date of De. Month	Day	Year	3. Time of De	
	/Medic	al .	4a. Facility Name (If not institution,	raldine	<u> </u>	LLen 4b. City. Town. or	Location of Do	05	· •	2005 ounty of Death	3:11	<b>₽</b> M
	Examin	er	1203 NORTH DUK			BALTI		auı	40.0	ounty or Death		
	Funeral			. Sex 7. Age (Ir	n yrs. last birthday)	If Under 1 Year	if Under 24 H	rs. 8. Date of Birt	th V Vear	9. Birth	place (State or Fe	-oreign
	Director		212-22-5826	1□M 2KDF 78	Yrs.	Months Days	Hours Mi	rs. 8. Date of Biri in. (Month, Da 04-26	[927	Cou	MD	
	and	-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation					IOd. Inside City L	Limits
	Maryl 1 shc	ţō	MD		BALTIM	ORE					1 Yes 2	□No
	h the or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	ntry?	
	23a c	ralD	1203 N. DUKEL	AND STREET			1216			USA		
	er dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14	. Race - Ameri Black, White,		
336	urs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1⊡ Yes 2.ZNvo	Specify:		s	pecify: BLA	CK	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene. Hygiene. Hygiene. Hygiene.	Completed by	15. Decedent's (Specify only highest		16a. Dece	dent's Usual Occupa	ation	vorkina	16b. Kind	of Business/In		
2	ithin ne.	mple	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	life.	DO NOT use retired	)	orking .				
	lied w lygier ther ti nt, th	ဝိ	17. Father's Name (First, Middle, La	ist)		Clerk		lame (First, Middle,	RET.			
Maryland	ld be fental likad ol	To Be		ONGUE				CINTA	ROSA	,		
ary	shou and M s mar umati		19a. Informant's Name/Relationshi		19b. Maili	ng Address (Street a				Town, State, Zip	Code)	
	and 2 ealth a n 27 i		BRUCE ALLEN/SC			9 ELDONE	ROAD/I	BALTIMORE		21229		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-1 show appring yor other traumatic avant, the Marilest Ever it are read by multilest an ance.		20a. Method of Disposition  1 → Burial 2 □ Cremation 3	☐Removal from State	-	matory or other place		Date		tion - City or To		
<u>=</u>	it. Pa irtmen rtant: njury	Ť	'4 □ Donation 5 □ Other (Special Service Li		ARBUTUS	MEM PK  2. Name and Addres				MORE, M N & SON		INC
Ba	permi Depa Impo any ii		amoo	a. Wort	in			TREET, BA				
			23a. Part. Enter the disease, or conshock, or heart failure. List or	omplications that caused the	death. Do not en	ter the mode of dying	g, such as card	íac or respiratory a	rest,		Approximate Interval Between	en
	Physician		Immediate Cause (Final disease or condition	Covc	noma.	d hu is	eatum	١		1	Onset and Dea	ath
	/Medical Examiner		resulting in death)	Due to (or as a co		of the v		1			77 . ( , 10 , 0 ,	4
١.		ē	Sequentially list conditions, if any, leading to immediate	b	onsequence of);							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
o,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a co	onsequence of):	-						
8760,	ate be	dical	,	d								
မ	certifica ding ph se as t	/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy					4 D-444-E		
Вох	death (	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23	d. Date of delive Month	Day Yea	ır
P.O.	res that the death certific igned by the attending p be detached for use as	Physician/Med	9 ☐ Unknown	9□ Unknown								
	es tha gned be de	by P	Part II. Other significant condition	s contributing to death but n	ot resulting in the u	inderlying cause give	en in Part I.				he cause of deat	
ord	w require been si should I		<u> </u>					1 🗆 ١	/es 2□	No 3 ☐ Prol	pably 4 Unki	nown
Records,	e law has b je 2 si	Completed			<del></del>			24a. Was autop			psy findings ava mpletion of caus	
	ysician: The lis certificate hadirector, page	e Co	25. Was case referred to medical				00 01	1 Yes	20 No		2 No	
Vita	ysicia s cert direct	0	examiner?	Hospital: 1   Inpatient	2 ER/Outpatier	nt 3 DOA Othe	ac.	eath <i>(Check only c</i> Home 5 X Resid		Other (Specia	iv)	
100	ding Phys h. After this funeral d	Ju: T	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injury Work		28d. Describe			,,	= 7.5
Sio	ttandii death. ctor: A	catio	2 Accident investiga 3 Suicide 6 Could no	t be		M 1 🗆 '	Yes 2□No					
Division of	lor At after of Dirac	Certification:	4 Homicide determin		- At nome, tarm, sti Specify)	reet, factory, office		City or Tov		vumber or Hura	al Route Number,	r.
_	ospital hours unaral ly filled		29a. Certifier 1 Certifying	Physicien: To the best of m	ıy knowledge, deat	h occurred at the tim	ne, date and pla	ice, and due to the	cause(s) ar	nd manner as s	tated.	
	1 2 4 E	fedical	(Check only 2   Medical E:	caminer: On the basis of exa and manner stated	amination and/or in	vestigation, in my or	oinion, death oc	curred at the time,	date and p	lace, and due to	the cause(s)	
	To the within To the comple	2	29b. Signature and title of certifier	la : AAG		29c. License	number	12	29d. Date :	signed (Month,	Uay, Year)	
1	A		30. Name and address of person w	Jaw Jon 1911	(Itam 22=) (Tim	D 00	J5+	1	- 5	114/0	7	
1	0		K. Harvisian MD	Joseph Dela	u HSOIC	28 N.	Futaws	t. Rully	40	. 2120	}	
			31. Date filed (Month, Day, Year)	32. Registrar's					-			
•	Sta Registr		de mai	8 2005 Bene								

ORIGINAL

			For State Registrar	State of	Marylan	-	artmen rtificate				_	giene Reg. No	2005	16691
	Physici	_	1. Decedent's Name (First, Middle, Patricia Ann	Last) Adams							2. Date of De Month May	ath Day 11	Year 2005	3. Time of Death 8:43A M
	/Medic Examin		4a. Facility Name (If not institution,	give street and numi	ber)		4b. City,	Town, or	Location of		114		County of Death	<del></del>
			9409 Parsley						tt Ci				Howard	
	Funeral Director		5. Social Security Number 216–48–1555	6. Sex 7	Age (In yrs. 58	la <i>st birthd</i> ay) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da 07-12-	th i <i>y, Year)</i> 1946	9. Birth Con Mary	iplace (State or Foreign intry) yland
			Usual Residence of Decedent								07 12	1740	mar.	y Lanu
	urylan show		10a. State 10b. County		10c. Cit	y, Town or Lo								10d. Inside City Limits
	Ba-f	ecto	Maryland Howard	l.					City	<i>J</i>				1 ☐ Yes 2 No
	with t	Funeral Director	10e. Street and Number 9409 Parsley Dr	ive			10f. Zip	210	42			-	zen of What Cou ced Stat	
	ns 23	era	11. Marital Status	12. Was Deced	lent Ever in U.	S. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - Amer	ican Indian,
036	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show deal Exactional be notilised at	þ	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Ford  1 Tyes 2  If Yes, Give  Year or Dat		- 1	lf Yes, spec 1 ☐ Yes	v	Specify:		Rican, etc.)		Black, White Specify: W	hite
5-0	72 hc 'natu	eted	15. Decedent' (Specify only highest	s Education grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	I Occupa	ition Juring mos	t of worki	ng	16b. Kir	d of Business/l	ndustry
Maryland 21215-0036	d within giene. rr then "	Completed	Elementary/Secondary (0-12)	College (1-4	4or 5+)		<i>DO NOT u</i> s ratio				3	5	Sales	
pur	be filed ntal Hygid ed other evant.	Be	17. Father's Name (First, Middle, L Elmer P. Mooney	ŕ							(First, Middle,	, Maiden	Sumame)	
Ž	s 1 and 2 should be I Health and Mental Item 27 Is marked other treumetic eve	ဥ	19a. Informant's Name/Relationsh			19b. Mailir	na Address	(Street a				er City or	Town, State, Z.	in Code)
	nd 2 sulth ar		James Adams (Hu			1.	•						ID 21042	. ,
Je,	ges 1 and 2 t of Health If item 27 or other tra	Βŝ	20a. Method of Disposition 1   Burial 2 □ Cremation	2 7 2 44 24		lace of Dispo emetery, crei	sition (Nan	ne of ther place	9)	C	ate	20c. Lo	cation - City or T	own, State
altimore,	Pages ment of ent: If it ury or o		1 ☐ Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (Sp			Johns	Ceme	tery	7   (		- (			ty, Maryland
Balt	permit. Pag Department Importent: I any injury o		21. Signature of aparticular L	of Cat	tonsv nsvil	ville, I	nc. 21228							
8760,	Priysician //Medical Examiner	al Examiner	23a. Part1. Enter the disease, or a shock, or heart/failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	ch line.	uence of):		NA Z	E4	Ap	rest Pass	_		Approximate Interval Between Onset and Death
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		th 2 ∏ Feta nt at time of d	Ideath 3	Ectopic pr					2	3d. Date of delik Month	very Day Year
rds, P	w requires that been signed b	by	Part II. Other significant condition	ns contributing to dea	uth but not res	ulting in the u	ndertying c	ause give	n in Part I	-	23e. Did t	6		the cause of death?
Vital Records,	The te had age	Completed									24a. Was autor perfo 1 Tyes		24b. Were aut prior to c death?	opsy findings available ompletion of cause of
Vita	ician: Certifical	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death	(Check only o			
of	Phys	1: To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of		ER/Outpatier 28b. Time of		8c. Injury	4 🗀 NU	rsing Ho	ne 5 K Resi		Other (Spec	ify)
lon	nding F tth. : After e funer	atlor	1 Natural 5 Pending 2 Accident investig	(Month	, Day Year)	Injury	М	Work	(? /es 2 □:			,.,		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could n 4 Homicide determine	and 286. Place C	of Injury - At ho g, etc. (Specif	ome, farm, str	eet, factory	, office			28f. Location (: City or To		1 Number or Ru	ral Route Number,
	To the Hospital or At within 24 hours after o To the Funeral Directompletely filled in by	edical	29a. Certifier Certifying (Check only one)	Physician: To the base	sis of examina	wledge, death tion and/or in	h occurred vestigation,	at the tim in my op	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. 1			290	License	number		./	29d. Date	signed (Month	. Day, Year)
	1	2		HT					341	73	3	Mai	4 13,	2005
ì	57		30. Name and address of passon	o completed cause	of death (Item	1 23а) (Туре,	Print)		1	1	Λ. Α		71/	
1			31. Date filed (Month, Day, Year)	100 P	gistrar's <b>M</b> gna	ture	- N.	<u> </u>	slvm	m, a	17/0	4	41045	>
	Sta Registr			AY 1 8 2008		was d	Y A	on well	8					

State of Maryland / Department of Health and Mental Hygiene

				·	С	ertificate of	Death	A	leg. No. 4 UU5	16692	
П	Physicia	an	Decedent's Name (First, Middle, Last)     Lillian	Dibbre				2. Date of Dea Month	Day Year	3. Time of Death 3:30am	
4	/Medic			Bibby			4h City Town or	May 16,2 Location of Death	4c. County of Deat	120	
أب	Examin	er	4a Facility Name (If not institution, give s Sunbridge Care	rreer ena number) Rehabilita	ation C	ntor	E1kton		Cecil	"	
	C		5. Social Security Number 6. Sex		yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs	R Date of Birth	Q Rist	hplace (State or Foreign untry)	
и	Funeral Director		145–16–3121		2 Yrs.	Months Days	Hours Min	Month, Day May 21,1	922 Oran	ge,NJ	
	and	ł	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits	
	Mary 1 sho	ţ	MD Cecil		Elkto	n				1 XYes 2 □ No	
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Co	untry?	
	th wit	aio	107 Chalice Driv	e		2192	1		USA		
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Department of Heatil and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28s-4 show any injury or other traumatic event, the Medical Evandrer must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	r in U,S. 1	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🖫 No		Specify Yes or No- rto Rican, etc.)			
2-0	72 ho	sted	15. Decedent's Educ (Specify only highest grade		16a. De	cedent's Usual Occu	pation during most of wo	orking	16b. Kind of Business/	Industry	
2121	within iene.	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ive kind of work done b. DO NOT use retire Homemaker	ed)		Own Ho	me	
Maryland 21215-0020	uld be filed fental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Robert Sorge					me (First, Middle, Lia Cappr			
Mary	d 2 shouth and A 1 is maintenant		19a. Informant's Name/Relationship (Type Sharon Morterud/D			ailing Address (Stree		Purel Route Number Elkton, M	r, City or Town, State, 2	Zip Code)	
ē,	Healt Healt Healt	- 1	20a. Method of Disposition		20b. Place of Dis	sposition (Name of	,	Date	20c. Location - City or	Town, State	
Baltimore,	Pages ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Act 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		irematory or other plate teaven Cerrete	ery	2005	East Hanover,	NJ	
Balt	Departi Departi Importi any inj pbce.		21. Signature of Funeral Service License	Ö		22. Name and Addr Charles 1501 Eas	ess of Facility L. Stevens t Fort Ave	Funeral Hi Baltimore	me Inc. MD 21230		
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the e cause on each line.	death. Do not	enter the mode of dy	ing, such as cardia	c or respiratory arr	rest,	Approximate Interval Between	
	Physician			-					į	Onset and Death	
,	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Cancer	of Lu	ng			; 	unknown	
	T E	ner		Chrenic	o to (or as a con	ng sequence of): uctive	Lunga	liseouse	ze Tinknava		
	executed and al-trans	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		e to (or as a con				İ		
68760,	e be e	cail	that initiated events	Due	to (or as a cons	sequence of):					
98	tificat ng phy as th	Medi	resulting in death) Last		(0. 25 2 5 5					22	
Š	th cer tendir or use	an	d			-			1		
0	the at	Physician/	Part II. Other significant conditions cont	ributing to death but no	ot resulting in the	e underlying cause gi	iven in Part I.	23b. Did to		to the cause of death?	
7	that the	Ph						1 🗆 Y	rea 2□No 3☑Pi	robably 4 □ Unknown	
Division of Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by						24a. Was a perfor	med?	Were autopsy findings available prior to completion of cause of death?	
E E	he lav e has age 2	E C						104		1 ☐ Yes 2 ☐ No	
ta	an: T tificat tor, pa	BeC	25. Was case referred to medical				26. Place of De	ath (Check only or		1111	
₹	ysicia is cer direc		examiner? 1 Yes 2 No	ospital:	2 ER/Outpa	tient 3 DOA	ther: 4 Nursing	Home 5□ Resid	ence 6 Other (Spe	cify)	
0 0	Attending Physician: or death. ector: After this certific by the funeral director,	ijon:	27. Manner of Death 1 ☑ Naturel 5 ☐ Pending investigation	28a. Date of Injury (Month, Dey Ye	28b. Time Injur	y Wo	ıryat ork? ]Yes 2∐No	28d. Describe h	ow injury occurred		
Visio	r Attend er deati rector: by the	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, Specify)			28f. Location (S City or Tow	Street and Number or Ri m, State)	urel Route Number,	
۵	ppital or ours afte oral Dir filled in	Cer	29a. Certifier 1 Certifying Phys	ician: To the best of m	v knowledge, de	eath occurred at the ti	ime, date end plac	e, and due to the o	ause(s) and manner as	s stated.	
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has: completely filled in by the funeral director, page 2:	Medical	(Check only 2 Medical Examin	er: On the basis of exa and manner stated	amination end/or	investigation, in my	opinion, death occ	urred at the time, o	date and place, and due	to the cause(s)	
	To Con		29b. Signature and the of certifier	SMD			se number 02332		29d. Date signed (Mont 5, 16,		
			30. Name and address of person who con S Sachda 231. Date filed (Month, Day, Year)  MAY 1 8 2	mpleted cause of death	(Item 23e) (Ty				10 21921		
Section 1	Sta	te	31. Date filed (Month, Day, Year)	32. Reo otrar's	Signature	Acade .					
dig.	Registr	al	MAY 1 8 2	005 Males	10 JS.	STATE OF THE STATE					

			For State Registrar	1 10000	State o	f Maryla		artmen					giene	005	166	93
	į.		Decedent's Name (Fit	irst, Middle, Las	st)							2. Date of De			3. Time of	Death
	Physici /Medic		MARY		BET	TS						Month MAV .	15 Day	2065	1710	М
	Examin		4a. Facility Name (If not	institution, give	street and nu	nber)		4b. City,	Town, or	Location of	of Death	1 7 1		ounty of Deat		
			Northwest 1	Hospital	Conte				ndo	Uston			3	altine		
	Funeral		5. Social Security Numb		ex □M 2 <b>E</b> F	7. Age (In yrs	. last birthday) Yrs.	Months Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th Year)	9. Birtt	nplace (State o	r Foreign
	Director		225 · 20 · 849 Usual Residence of Dec			00						11, 75.	142	Τ	Vrt	
	nylane how			b. County			ity, Town or Li								10d. Inside Ci	1
	Ba-f s	Director		BALTIM	ORE	G	NNVN	OAK							1 🗆 Yes	2 No
	with the		10e. Street and Number	- 4	Court			10f. Zip	212	17			10g. Citize	on of What Co USA	untry?	
	eath	Funeral	1 SUMME	KSEI		edent Ever in I	J.S. 13.	Was Dece		• •	igin? (Spe	ecify Yes or No	)- 14	I. Race - Ame	rican Indian.	
တ	after d	듄	1 Never Married	2 Married	Armed Fo	rces? 2 <b>M</b> No						ecify Yes or No Rican, etc.)		Black, White	e, etc.	
93	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show citeal Evan art must be rediffed at	d by	3 NWidowed 4 □	Divorced	If Yes, Gir Year or D	ve ates:		1 Yes	2 UZ- NO	Specify:			5	Specify: Bl	ACK	
15-(	"natu	lete	(Specify o	Decedent's Ed only highest gra	ducation de completed)		(Give	edent's Usu s kind of wo DO NOT u	rk done o	turing mos	t of worki	ng	16b. Kind	d of Business/	ndustry	
21215-0036	be filed within 72 hc tal Hygiene. Id othar than "natur evant, IT = Medical	Completed	Elementary/Secondar	ry (0-12)	College (	1-4or 5+)	TEACH			ISTAN	UT		EDU	CATION	J	
br	be filed tal Hygie d other evant, I	BeC	17. Father's Name (Firs				,			18. Mothe	er's Name	(First, Middle	, Maiden S	umame)		
ylar		10 E	ALPHEUS	LAW						Susii	EN	ICKNE	3			
Maryland	and and is m		19a. Informant's Name/	_	Type, Print)							I Route Numb			ip Code)	
	s 1 and 3 f Health itam 27 othar tr		MAE CAR 20a. Method of Disposit			20b.	Place of Disp	osition (Nati	me of		., CH	TONSVII		ation - City or	Town, State	
nor	0 0		1 ■ Burial 2 □ Cr	remation 3 🗀		State	cemetery, cre IRRISON	· ·		· i	TK 24	4.05		ics mi		aı
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral		-	QF						JERAL !			CO 11	iD
ä	De Comment		Vane	m (			51	51 BAI	TO. N	ATL P	KE,	BALTO.	mo	21229		
			23a. Part1. Enter the d shock, or heart fai	lisease, or com ilure. List only	plications that one cause on e	caused the dea each line.	ath. Do not en	iter the mod	de of dying	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Bets	ween
	Physician		Immediate Cause (Fina disease or condition resulting in death)	al	a f.	neuma	2016								Onset and t	Jeath
	/Medical Examiner		resulting in death)	(	Due to	(or as a conse	quence of):								C	7
		ē	Sequentially list conditi if any, leading to immediate. Enter Underlying	ons, diate	b. Due to	(or as a conse	quence of):									
	d d ansit	Examiner	cause. Enter Underlyin Cause (Disease or injurathat initiated events	ng ry	c											
o o	be executed sician and burial-transit		resulting in death) Last			(or as a conse	quence of):									
68760,	9 3 9	lical			d									-		_
9 xo	ding b	/Mec	IF FEMALE:		23c. If yes, ou	tcome of predi	nancy	-					0.0	N. D. t f . d l		
Во	leath certifical attending phy I for use as th	cian	23b. Was decedent pre in the past 12 mor	nths?	1 Live I	oirth 2 Fei	tal death 3	□Ectopic p					23	3d. Date of deli Month	,	/ear
0	that the de led by the a detached t	Physician/Med	1 ☐ Yes 2ÆNo 9 ☐ Unknown		9□ Unkn											
ď,	The law requires that the ate has been signed by the page 2 should be detache	by P	Part II. Other significan	nt conditions o	ontributing to d	eath but not re	sulting in the t	underlying o	cause give	en in Part l	l.	23e. Did	tobacco us	e contribute to	the cause of d	eath?
ord	w require been signal		Chrene	Obst	rackn	e ful	Menar	J [	):250	4		1,200	Yes 2	lNo 3∏Pr	obably 4 DL	inknown
Records,	e lawr has be je 2 sh	Completed	Diabetes									24a. Was	psy	prior to o	topsy findings a completion of ca	available ause of
			Obesity						_			1 Yes	ormed? 22 No	death?	20 No	
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred examiner?	to medical	Hospital:		750/0	20 0	Othe			(Check only		CO15 (C	-6.)	
ō	두 등 등	$\vdash$	27. Manner of Death		28a. Date	of Injury	☐ ER/Outpatie 28b. Time o		28c. Injury Work	4 □ NI		me 5 Res 28d. Describe			ory)	
ion	Attanding F or death. actor; After by the funer	atio	1 Natural 5 2 ☐ Accident	Pending investigation		th, Day Year)	Injury	М		Yes 2 🗍	No					
Division	or Attand after death Diractor;	Certification;	3 Suicide 6	Could not b determined	286. Placi	of Injury - At ing, etc. (Spec	home, farm, st	treet, factor	y, office				(Street and wn, State)	Number or Ru	ıral Route Num	ber,
D	urs af urs af arai Di		20. 0.00	V0												
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical			nysician: To the back of the b											)
	To the within To the	Me	29b. Signature and title	of certifier				29	c. Licens	e number				signed (Monta		
}			Dockar	h don	anos	- De			H5	393	39		5/	15/	2005	
	0		30. Name and address 5401 0	of person who	completed cau		om 23a) (Type		4D	211	33	(Babo			1,00	)
	Sta Registi	100	31. Date filed (Month)	AY°I'8	2005 32.	gistrar's Sign	nature	Const	9							

		1 - For Amend Item 8 per	rп,6040,1	LU/ Kg/	Hilleate of L	Death			11600
Physici	an	Decedent's Name (First, Middle, Last)     ALICE FAYE BUTLER					2. Date of Death Month	Day Year	3. Time of Death
/Medic Examir		4a. Facility Name (If not institution, give street and t	number)		4b. City, Town, or	Location of Death	May 1	4c. County of Dea	
LAdijii	iei	6225 O'Donnell Stre			Balti				
Funeral		5, Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign
Director		Usual Residence of Decedent	61	Yrs.			01/13/1	<b>944</b> Nor	th Carolina
yland how		10a. State 10b. County	10c. City,	, Town or Lo	cation				10d. Inside City Limits
72 hours after death with the Maryland naturel; or items 23s or 28e-f show dical Exar, a sermant be invitibled at	Director	Maryland	Bal	ltimo	re				1 X Yes 2 □ No
with th	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
ns 23	Funeral	6225 O'Donnell Stre	ecedent Ever in U.S	6. 13.1	21224 Vas Decedent of Hi		ecify Yes or No-	United 14. Race - Am	
the Higher with 7.2 froms after beath with the Maryran tal Higher 4.4 from 4.2 a or 2.8 a f show do ther than "naturel", or items 2.3 a or 2.8 a f show event, the Marylon Exarch arrival be rediffed at	by	Armed	Forces? s 2√2 No GiveX	'	Yes, specify Cuba	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
natura Jical B	Completed	15. Decedent's Education (Specify only highest grade complete)	d)	16a. Deced	lent's Usual Occupa	ition	ina 1	6b. Kind of Business	s/Industry
then.	mpi		(1-4or 5+)	life. I	DO NOT use retired,	)	9		
Hygie ther t	e Co	10 17. Father's Name (First, Middle, Last)		Homer	naker	18. Mother's Nam	e (First, Middle, M	Domesti	C
	o B	J B Hardin				Rosie	Oxendi	ne	
th and Men 7 ie marke traumetic	-	19a. Informant's Name/Relationship (Type, Pnint)		19b. Mailin	g Address (Street a	nd Number or Run	al Route Number,	City or Town, State,	<sup>Zip Code)</sup> 21224
= ~ -		Gerald Butler-Spouse		6225	O'Donne	ell Stre	et, Ba	ltimore,	Maryland Town, State
0		20a. Method of Disposition   ★□ Burial 2 □ Cremation 3 □ Removal from	m State ce	metery, cren	sition (Name of natory or other place	7			
		. ♣ Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	/ Cak		Cemetery	5/17/	2005 B	altimore,	Maryland
Departr Importe eny inju		19KA+6/22 0 (1 /1/	Chos Cit	T P Da	Name and Addres Wid J. We	eber Fune	ral Home	s, P.A.	
		23a. Part1. Enter the disease, or complications tha	t caused the death.	Do not ent	1 S. Chest of the mode of dying	ster Stro	et, Balt	imore, MD	21231 Approximate
nysician		shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition	act rice	Cine	10				Interval Between Onset and Death
Medical		resulting in death)	o (or as a conseque	ence of):					// //mas
aminer	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to	o (or as a conseque						
nsit	nine	cause. Enter Underlying Cause (Disease or injury	o (or as a conseque	ence or):					
in and ial-tra	Examine	that initiated events c	o (or as a conseque	ence of):					
physician and the burial-transit	edicai	d							
ding pl	/Med	IF FEMALE:	utcome of crosses		<u></u>				
attending p I for use as I	Physician/M	in the past 12 months?	outcome of pregnan birth 2  Fetal of gnant at time of dea	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
by the ached	hysi	9 Unknown 9 Unk			, a (apacan) /				
gned be de	by P	Part II. Other significant conditions contributing to	death but not resul	ting in the ur	iderlying cause give	n in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
been si should b							1 🗆 Yes	s 2 No 3 P	robably 4 Unknown
ω cv	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
tificate ha tor, page	e Col						perform 1 Yes 2	-	s 2 No
is certifi director	o Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) Hospital:	Inpatient 2□E	R/Outpatien	t 3□ DOA Othe	_	Check only one	nce 6 Other (Spe	
멸	T : U	27. Manner of Death 28a. Dat		28b. Time of Injury	28c. Injury Work		28d. Describe hov		эспу
ta : e	atio	2 Accident investigation	, Day 1021/	III I I I I I I I I I I I I I I I I I		es 2 □No			
within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	ertification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pla bui	ce of Injury - At hon Iding, etc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	lural Route Number,
ours a	ai Ce	29a. Certifier Certifying Physician: To t	he best of my know	rledge death	occurred at the tim	e date and place	and due to the car	use(s) and manner a	s stated
n 24 h	edici	(Check only 2 Medical Examiner: On the	basis of examination	on and/or inv	estigation, in my op	inion, death occur	ed at the time, da	te and place, and du	e to the cause(s)
To the comp	Σ	29b. Signature and little of certifier	12		29c. License			d. Date signed (Mon	
h -		Valu Calytafel	mo		024	356		1 ay 16,	405
10		30. Name and address of person who completed on	use of death (Item 2		Print) Weine	bey Cond	4 Centy	May 16, at Frank	la guer
Sta	te	31. Date filed (Month, Day, Year) 32.	Registrar's Signatu		3 Frank	ue of	or well	1 mon 1	10 0113)
Sta Registr		MAY 1 8 2005	nagistrar s Signato	L A	100				

			For State	State	of Marylan		irtment of H tificate of I		nd Me		i.m.	05	16695
			Registrar  1. Decedent's Name (First, Middle	e, Last)		Cei	unicate of t	Jeani	2	Re Date of Deat	eg. No. h		3. Time of Death
	Physici			lexander	Franklin	n Black	r			Month May 1.	Day	Year	7:54A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution			Didei	4b. City, Town, or	Location of	Death	may 1.	T	y of Death	7.J4A
			Carriage	Hill Bet	hesda		Bethes	da			Mon	ntgome	erv
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. g	B. Date of Birth (Month, Day,			lace (State or Foreign
в	Director		088-14-3363	1 <b>X</b> M 2□F	86	Yrs.	Wichtis Days	riodis	D	ecember	27, 1918		ew York
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	danyl f sho	5	D.C.			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ahina	ton				1 Y Yes 2 □ No
	1588 1011	Director	10e. Street and Number				10f, Zip Code	shing	LOII	1	0g. Citizen of	What Cour	ntry?
	3e or		3101 New 1	Mavico An	anua N I	.ī		20016					States
	death	Funeral	11. Marital Status		edent Ever in U.	.S. 13. \	Vas Decedent of Hi	spanic Orig	in? (Speci	fy Yes or No-	14. Ra	ce - Americ	an Indian,
ထွ	after or ite	교	t ☐ Never Married 2X Mar	ried 1 Yes	2 No		fYes, specify Cuba I□Yes 27© No	n, mexican, Specify:	Puerto HI	can, etc.)		ack, White,	etc.
21215-0036	72 hours after death with the Maryland Inatural; or Items 23e or 28e-f show Jical Exaciliar const be notified at	d by	3 Widowed 4 Divorced	Year or	Dates: WWII						Speci		White
<u>.</u>	nati	Completed	15. Deceden (Specify only highe	t's Education st grade completed	)		lent's Usual Occupa kind of work done of		of working		16b. Kind of E	Business/In	dustry
7	within ene. than	ğ	Elementary/Secondary (0-12)	College	(1-4or 5+)	Dire	ctor of Public	İnteri	natio	na1	Umirra	1	Pictures
0 0	Hygid Hygid Sther	ပိ	17. Father's Name (First, Middle,			]	PUDIT		r's Name (	First, Middle, I			rictures
au	ld be ental ked o	To B										ζ	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene and Health and Mental Hygiene That natural, or items 23e or 28e-4 show item 27 is marked other than "natural", or items 23e or 28e-4 show other traumatic event, I'm Mudical Exacilities in colling at	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number)										Code)
	1 and 2 Health a lem 27 is	ľ	Victoria Black/ Daughter 1301 20th Street N.W. Washing									.C. 2	0036
ore	of He of He filter		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation	2 Domewal from	20b. P	lace of Dispo	sition (Name of natory or other place Nery	e)	Dai		20c. Location	- City or To	wn, State
altimore,	Pages ment of I ant: If Its ury or o		`4 □Donation 5 □Other (S		State	Cremat	nery orium Inc		May 16, 2	005	Bethe	sda, 1	Maryland
Balt	permit. Pages Department of Important: If It any injury or o		21. Signature of Fundral Service	Licensee	<u>′</u> моо:	335 Be	Name and Address thesda-Ch thesda, M	evy C	Rober hase, nd 20	t A. P Inc. 1814-35	<del>ሃ</del> ጛያት ዋ 01	y Fun Iscon	eral Home/ sin Avenue
ľ			23a. Part1. Enter the disease of shock, or heart failure. List	complications that									Approximate Interval Between
	- Priysician	E 0	Immediate Cause (Final disease or condition	only one odder on		0000		_	tas (1				Onset and Death
	/Medical		resulting in death)	a Due to	(or as a conseq			- ( (	100.(1	200			
	Examiner		Sequentially list conditions,	b. C.	OPOL	PSAC	504	255	Ps	DUSE	5845		
	sit ad	ine	l arly, leaving to immediate cause. Enter Underlying Cause (Disease or injury	Duate	(or as a conseq	uence of):							
	and I-tran	Examiner	that initiated events resulting in death) Last	c	(or as a conseq	uence of):							
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687	ficate p phys	edicai		d									
Box	The law requires that the death certifics to has been signed by the attending phage 2 should be detached for use as it	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		Te				23d. D	ate of delive	эгу
m m	death	sicia	in the past 12 months? 1 □ Yes 2 □ No		birth 2 ☐ Feta gnant at time of d		Ectopic pregnancy Other (specify)				М	lonth	Day Year
P.O.	at the de by the a stached	hys	9 🗆 Unknown										
	res that igned b	þ	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	nderlying cause give	en in Part I.			757.000		he cause of death?
orc	w require been si should b	eted								, , , ,	- 1		-
Records,	e law has b	Completed								24a. Was a autops perform	SV	. Were auto	psy findings available mpletion of cause of
										1 Yes	2.DE NO	1 Yes	28 No
Division of Vital	Physician: The this certificate hiral director, page	) Be	25. Was case referred to medica examiner?  1 ☐ Yes 2 ② No	Hoenital:		1500	• 30 004 Oth	0.00		Check only or			
o	ding Phys h. After this funeral di	1; To	27. Manner of Death		Inpatient 2 e of Injury nth, Day Year)	ER/Outpatien 28b. Time of	I 3L DOA	4 (4) (4)		e 5 🗌 Reside 3d. Describe he			7)
ion	nding I ith. :: After e funer	atio	1		nth, Day Year)	Injury		k? Yes 2.∐.N	No				
Vis	or Attency after death Director:	ii	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Place	e of Injury - At he ding, etc. (Specif	ome, farm, str	eet, factory, office		28	If. Location (Si City or Town		ber or Rura	al Route Number,
	Hospitel or Attending Physician: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director,	Certification;	_							,			
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical		ng Physician: To the Examiner: On the and ma									
	To the within 2 To the complet	ŭ	29b. Signature and title of certifie	" ()		1	29c. Licens	e number		2	9d. Date sign	ed (Month,	Day, Year)
)	111		/ \ \ \ \ \ \ \	1 / 1	XX	$\Lambda$	He	205	28	0	5-1	6-2	200
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7	0 /(		Anushiravan Da 31. Date filed (Month, Day, Year,						#201	l Rockv	ille,	Mary1	and 20850
	Sta Registi		51. Date med (Month, Day, Year,		Registrar's agna	we h	& Spark	1					

	1 - State Registrer	aryland / Depa <i>Cei</i>	artment of H rtificate of L		F	leg. No.	]5	16696
Physician	Decedent's Name (First, Middle, Last)     SIMON	BRAV	ERMAN		2. Date of Dea		Year	3. Time of Death 5:55 PM M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) ARDEN COURT OF TOWSON		4b. City, Town, or	Location of De	eath	4c. Count		BALTIMORE
Funeral Director	218-12-8004 <sup>1</sup> X <sup>M 2□F</sup>	e (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Birtlin. MAY 12	1924	9. Birthpl Count	lace (State or Foreign try) MD
ne Maryland Se-f show pillied at	Usual Residence of Decedent	10c. City, Town or Lo	ON					0d. Inside City Limits 1 ☐ Yes 2 🛱 No
3e or 2	10e. Street and Number 20 JUDGES LANE		10f. Zip Code	21204		10g. Citizen of	What Coun	USA
titled within 72 hours after death with the Maryland Hygiene. Hygiene. The Trattral, or Items 23e or 28e-1 show ent, the Maryland Exam per must be notified at the Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Armed Forces?  1 Married 12. Was Decedent Armed Forces?  1 Married 12. Was Decedent Armed Forces?  1 Married 12. Was Decedent Armed Forces?  1 Married 12. Was Decedent Armed Forces?	No I	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No- derto Rican, etc.)	14. Ra Bla Speci	ce - America ck, White, e	
at and 2 should be filed within 72 hour theath and Mental Hygiene. Item 77 is marked other then "natural other treumatic event, the Medical Ex	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of ()	working	16b. Kind of E		dustry
Hygie other the Coi	17. Father's Name (First, Middle, Last)	MECH	ANICAL EN		Name (First, Middle,	·		.K CONDITIO
to year of the state of the sta	ABRAHAM		ERMAN	DORA		City of Town	-	TROSKY
and 2 sh and 2 sh auth and n 27 is n	19a. Informant's Name/Relationship (Type, Print)  MARJORIE BRAVERMAN / WIFE				SON, MD 2		i, State, Zip	Code)
Pages 1 and 3 nent of Health nert if item 27 iry or other tr	20a. Method of Disposition 1		matory`or other plac		Date	20c. Location		
permit. Pages of Department of the Important: If ite any injury or of once.	'4 □Dopetion / 5 □ Other (Specify)  21. Starture of Funeral Service Liganses		2. Name and Addre	ss of Facility	SOL LEVINS	SON & B		INC.
Physician	23a. Part1. Enter the disease, conclication at a caused shock, or heart failure. List only one 3a e on each li Immediate Cause (Final disease or condition	the death. Do not en			N ROAD - F diac or respiratory and June		LLE, <u>r</u>	Approximate Interval Between Onset and Death
/Medical Examiner	resulting in death)	a consequence of):	)		1		0	1
executed executed in and ial-transit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of):						
a pricing	resulting in death) Last Due to (or as	a consequence of):						
The law requires that the death certificate be ate has been signed by the attending physicis page 2 should be detached for use as the bucompleted by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	1		1	ate of delive	ery Day Year
es tha igned be det	Part II. Other significant conditions contributing to death b	out not resulting in the t	underlying cause gru	en in Part I.		obacco use co Yes 2 No		he cause of death?
eicien: The law requir eicien: The law requir s certificate has been s lirector, page 2 should					24a. Was auto perfo		prior to con death?	opsy findings available impletion of cause of
ng Phyeicien for this certific for this certific for To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpati	ury 28b. Time of	of 28c. Injur	ner: 4 □ Nursir	Death (Check only on page 14 page 15 Page 14 page 15 Page 14 page 14 page 15 Page 14 page 15 p	dence 600	ther (Specif	more in the second
tel or Attending P rs after death. al Director: After ted in by the funera	3 Suicide 6 Could not be determined 28e. Place of In building, e	jury - At home, farm, si tc. <i>(Specify)</i>	treet, factory, office		28f. Location ( City or To		nber or Rura	al Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	29a. Certifier 1 Certifying Physician. To the best (Check only one) 2 Medical Examiner: On the basis of and manner st	of examination and/or in	nvestigation, in my o	ppinion, death o	nace, and due to the occurred at the time,	date and place	and due to	o the cause(s)
To t To t com	29b. Signature and title of certifier	M) 		0433	3	29d. Date sign	16, 2	Day, Year) 2005 MO 21204
10	30. Name and address of person who complete gues of a complete gues of a complete gues of a complete gues of a complete gues of a complete gues of a complete gues of a complete gues of a complete gues of a complete gues	6701	N CME	RLES	ST 1	SALTIME	ONE	MO 21204
State Registrar	MAY 1 8 200	rar Signature	: Books					

				partment of Health and Mental Hygie ertificate of Death	10001
ı	Physici /Medic Examin	al.	CATCIS CHALLES COUVER.	2. Date of Death Month 5  4b. City, Town, or Location of Death	Day Year 3. Time of Death 5:00 A M 4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 415-46-3011 12 M 2 F 74 Yrs.	Months Days Hours Min (Month Day Ye	9. Birthplace (State or Foreign Country) Tenn.
	e Maryland Ba-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or  MD Baltimore	Location Middle River	10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	h with th	al Director	10e. Street and Number 63 Torque Way		. Citizen of What Country? JSA
036	within 72 hours after death with the Maryland ene. then "natural", or flems 23a or 28a-f show Ira Madical Exartifier results to rediffed at	by Funeral	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
9500-61212	od within 72 hours glene. er then "natural", if to Medical Ext	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8th  16a. Dec (Gin (Jife)  College (1-4or 5+)  Wel	ve kind of work done during most of working	b. Kind of Business/Industry teel Corp.
yland	should be filed nd Mental Hygi marked other umatic avent, I	To Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Mai Eliza Frost	iden Sumame)
Nar	s 1 and 2 should f Health and Mer item 27 is marke other treumatic			ailing Address <i>(Street and Number or Rural Route Number, C</i> 3 Torque Way Baltimore	
altimore,	permit. Pages 1 a Department of Hee Importent: if item any injury or othe		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Discemetery, completely, co	sposition (Name of Date 200 rematory or other place)	c. Location - City or Town, State Baltimore MD
Ball	permit. Departi Import any inj		21. Signature of Euroral Service Licenside	22. Name and Address of Facility ConnellyF 300 Mace Ave. Baltime	uneralHomeofEssex
	Physician /Medical Examiner		Due to (or as a consequence of):	enter the mode of dying, such as cardiac or respiratory arrest,  em organ Failure  AA	Approximate Interval Between Onset and Death 2 Months
6/60,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		
C. BOX 6	requires that the death certificate een signed by the attending phys nould be detached for use as the	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
rds, P	equires that en signed b ould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the Perforated ISChemic Small		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Records,	The larate has	Completed	CAD	24a. Was an autopsy performed 1 ☐ Yes 2 ☑	
	Physiclen: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati	26. Place of Death (Check only one) ient 3 □ DOA Cther: 4 □ Nursing Home 5 □ Residence	e 6 ⊡Other (Specify)
DIVISION OF	To the Hospitel or Attending Physicien: which 24 hours after deals To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death  1	of 28c. Injury at 28d. Describe how	
Š	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	City or Town, S	
	the Hosp in 24 hou he Fune pletely fil	edical	29a. Certifier (Check only one)  1	eath occurred at the time, date and place, and due to the caus investigation, in my opinion, death occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To Too	∑ 	29b. Signature and title of certifier  Wassin ER-Hith wo	DE1251 5	Date signed (Month, Day, Year)
1			30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Wo-55 m El-Hitt 9000 From 131. Date filed (Month, Day, Year) 32. Registrar's signature	RIIN Squafellive	Baltimore, Ml 2/23
•	Sta	te	MAY 1 8 2005	C. Goerle	,

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 8:50 A M JOSEPH LESTER COOK 05 2005 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARINER HEALTH OF FOREST HILL FOREST HILL, HARFORD If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 27, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1₽M 2□F Chiro 1929 288-24-5681 75 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. Ite Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Md. Harford Bel Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 118 Chatham Road U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐¥es 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 21 No white Specify γ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 years mechanic stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Veronica Hartman Joseph Grant Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Dunham/stepdaughter 118 Chatham Road, Bel Air, Md. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Teremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 5/17/2005 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. Birana Welle 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Comes /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician esn IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months?
1 Yes 2 No Day ģ Month Vear 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Was a autopsy performed? 24a. Was an this certificate has 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Manner of Death 28d. Describe how injury occurred After Injury Natural 2 Accident 5 Pending 1 🗌 Yes 2 III No investigation death the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 D32255 May 16 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN, 615 W. MACPHAIL ROAD, BEL AIR, MD 31. Date filed (Mor 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

			For State Registrar	State of Marylan		artment of I		d Mental I	Hygien	nnn	16000
Ī	Physici		1. Decedent's Name (First, Middle, Las RoBERT	0	60.	LLINS		2. Date of Month	D	ay Year	3. Time of Death J
>	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,		eath		c. County of Dea	
	Funeral			PITAL CGN 7. Age (In yrs.		If Under 1 Year		Hrs. 8. Date of	Birth	Balt 9. Bir	imore City thplace (State or Foreign ountry)
	Director		216-94-5321	M 2□ F 4	Yrs.	Months Days	Hours N		, <i>Day, Year</i> ary 5, 19		Maryland
	aryland show	_	10a. State 10b. County	10c. Cit	y, Town or Lo	ocation		Janac	ily 0, 10		10d. Inside City Limits
	r 28e-f	Director	Maryland Baltin  10e. Street and Number	nore City		Ba 10f. Zip Code	altimore Cit	y	10g. C	itizen of What Co	1 Yes 2 □ No
	23a o		4211 Massachussetts /	\ve			2122	9			S.A
036	be filed within 72 hours after death with the Maryland that Hygliene. So other then "naturel", or items 23a or 28e-f show event, it a Madical Examinational the rotified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of life Yes, specify Cub 1 ☐ Yes 2 No		? (Specify Yes or uerto Rican, etc.	r No- )	14. Race - Ame Black, White Specify:	
12-0	"natur	ieted	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occu kind of work done	during most of	working	16b. I	Kind of Business	
Maryland 21215-0036	filed withir Hygiene. other then ant, the M	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	DO NOT use retire	Disabled			Dis	sabled
and	uld be filed Aental Hygid rked other tic event, II	Be	17. Father's Name (First, Middle, Last)					Name (First, Mic	ddle, Maide	n Sumame)	
aryle	s 1 and 2 should be f Health and Mental Item 27 Is marked other treumatic ev	To	Grove 19a. Informant's Name/Relationship (7	Collins Type, Print)	19b. Mailii	ng Address (Stree	t and Number o			Rohrbach or Town, State,	Zip Code)
	5 = 7 I		Mrs. Alberta Collins	Mother	4	211 Massac	husseţts A	ve. Baltimo	re, Man	/land 21229	)
nore	Pages 1 ar		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	lace of Dispo	esition (Name of matory or other pla	ice)	Date	20c. I	_ocation - City or	Town, State
Baltimore,	permit. Pages Department of Importent: If I any injury or once.		21. Signature of Funeral Service Scen	500 D. MUZ	rest Law	n Memorial ( 2. Name and Addre	Sarden's ess of Facility	05/21/2005		Marriottsvi	lle, Maryland
	205 20		23a. Part1. Enter the disease, or compshock, or heart failure. List only	Clubult	h. Do not ani	Slack	Funeral Ho	me, P.A. Dia Pike Elli	cott City	. MD 2104:	Approximate
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	5 (F	ROTEUS			ry arrest, J		Interval Between Onset and Death
	Examiner		Sequentially list conditions.	b. MULTIPLE	LE	FG AB	SCESS	ES			5 months
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
x 68	entifical ding phy se as th	/Medi	IF FEMALE:	23c. If yes, outcome of pregna	anou.						
P.O. Box	n requires that the death certific been signed by the attending p should be detached for use as:	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnand Other (specify)	÷y			23d. Date of de Month	livery Day Year
ords, F	equires tha sen signed iould be del	ted by P		ILURBAND V							o the cause of death?  robably 4 □Unknown
Division of Vital Records,	S 2	Completed by	MORBID OBEST	7.4				a p 1 □ Ye		prior to death?	utopsy findings available completion of cause of
<u>=</u>	ysicie is certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1 X Inpatient 2 □	ER/Outpatier	nt 3□ DOA Ot	hor	Death (Check or ng Home 5 - F		6 □Other (Spe	ecily)
sion o	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: Atter this certificate ha completely filled in by the funeral director, page	Certification;	27. Manner of Death  1 SNatural 5 Pending 2 Accident investigation		28b. Time o Injury	Wo				ury occurred	
<u>X</u>	vitel or Att urs after d rel Direct		3 Suicide 6 Could not be determined	building, etc. (Specif	fy) 			City or	Town, Sta	te)	ural Route Number,
	n 24 hor e Fune letely fi	Medical	29a. Certifier 1. ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, deat ition and/or in	h occurred at the t vestigation, in my	ime, date and p opinion, death o	lace, and due to occurred at the ti	the cause( me, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
	To the h within 24 To the R	Me	29b. Signature and title of certifier	11/1			se number			ate signed (Mon	
,	1//	2	30. Name and address of person who	completed cause of death (Iter			ORES		1 1 1 1	119 - 17	7-2005
_	47		MANJUNATH NIA	RKANDAYA	3001 3	S. HANOV	or ST	REET, E	BALTIN	TURE !	MD 21225
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	TU V					

DHMH 17 Rev 1/2001

ORIGINAL

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Anne Louise Crim 12, MAY 2005 6:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Director 213 18 1944 X July 15 1913 Baltimore, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "netural", or items 23a or 28e-f show If a Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Towson Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 West Road 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ thio Specify: White þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) ΙPN Visiting Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hiant: If itam 27 is marked off Adolph R Brandt Marie Hirmelman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a If itam 27 is or other trans Richard Abraham, Esq. 305 Washin ton Avenue Suite 203 Towson, Md. 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Western Cemetery May 16 2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc. 7401 Belair Road Beltimore, Maryland 21236 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (\*\* as \* consequence of): Pnysician /Medical Examiner heart failure ongestive Sequentially list conditions, in any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical physi the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ fibrillation 2000 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 3□ DOA 27. Manner of Death 28c, Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after deat uneral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 4 - Homicide To the Hospitel within 24 hours a To the Funeral C Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 0058082 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles St Suite 601 Mark Gosnell

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's

2005

MAY 18

			State Registrar	tate of Mar	yland / Depa <i>Cei</i>		of Health of Death	)	Reg	- / HH!	5 16701
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Anna Leitch Carr						2. Date of Death Month May 12,		12:30 A M
	Examir	er	4a. Facility Name (If not institution, give stree 3589 Riva Road	at and number)			own, or Location Davidson			4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 1 M	2XF 7. Age 84	(In yrs. last birthday) Yrs.	If Under 1 Months	Year If Under Days Hours	Min.	8. Date of Birth (Month, Day, Yo 8-7-1920	ear) 9. Bi	nthplace (State or Foreign Jountry) ryland
	be filed within 72 hours after death with the Maryland the tygiene. All the thing that the filed the them that the filed the the modified at event. The Medical Examiner must be notified at	rai Director	Usual Residence of Decedent 10a. State 10b. County  Maryland Anne Arund 10e. Street and Number 3589 Riva Road	lel		vidsor 10f. Zip C	21035			. Citizen of What C	
215-0036	2 hours after de atural', or items ral Eran i er m	ted by Funeral	1 Never Married 2 Married 3 X Widowed 4 Divorced	Was Decedent Ev Armed Forces? I ☐ Yes 2 No f Yes, Give Year or Dates:	16a. Deced	1 □ Yes 2	Occupation	:	16	14. Race - Am Black, Wh Specify: V	ite, etc. Vhite
פוצוז	filed within 7 Hygiene. Ither than "n Int, the Medi	Completed	(Specify only highest grade co	mpleted) College (1-4or 5+)	life. I	kind of work DO NOT use emaker		st of working		Home	
_	0 m 0 %	To Be C	17. Father's Name (First, Middle, Last)  Thomas Ralph Le	itch	110111	<u>Cital Ci</u>	18. Moth		First, Middle, Ma et Eliza		eland
Mar	nd 2 sho alth and l 27 is ma ir trauma		19a. Informant's Name/Relationship (Type, Martha A. Gibbs/ Dau	•						ity or Town, State, nville, N	
nore,	ages 1 a int of Hea t: If Item y or othe		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Remo  4 □ Donation 5 □ Other (Specify)	val from State	20b. Place of Dispo cemetery, cres Hillcrest	natory or oth	er place)	Da 5 <b>–1</b> 6–0		c. Location - City o	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic e once.		21. Signature of Funeral S ce cen e	_	22	. Name and	Address of Facil	ity Geo	rge P. K	nnapolis alas Fune gewater,	eral Home
,00	Certificate be executed for the partial state of th	edical Exan iner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a	ne death. Do not ent.  A STATE Consequence of):  consequence of):  consequence of):	1	of dying, such as		respiratory arrest		Approximate Interval Between Onset and Death C
2	death e atter d for u	Physician/M	in the past 12 months?	f yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	☐ Fetal death 3 ☐	Ectopic preg Other (spec				23d. Date of de Month	elivery Day Year
cords, P	w requires that the been signed by the should be detache	by	Part II. Other significant conditions contrib	uting to death but	not resulting in the ur	nderlying cau	use given in Part	l.		١.	to the cause of death? Probably 4 Unknown
Hec	The law ale has b p: ge 2 sl	Completed							24a. Was an autopsy performed	24b. Were a prior to death?	utopsy findings available completion of cause of s
Division of Vital	itending Physician: The feath.  Voc. After this certificate the funeral cirector, pog.	ertification: To Be	Z Accident investigation	8a. Date of Injury (Month, Day 1	28b. Time of Injury	M 280	Other: 4 No. Injury at Work?	ursing Home 28	d. Describe how		
Z	ne Hospitellor Attending F n 24 hours after death. na Funeral Director: After i pletely filled in by the funera	O	4 Homicide determined	building, etc.					City or Town, S	State)	iural Route Number,
		<b>l</b> edical	one)	On the basis of e and manner state	xamination and/or inved.	estigation, ir	n my opinion, de	ath occurred	d at the time, date	and place, and du	e to the cause(s)
10	To To To To To To To To To To To To To T	Σ	29b. Signature and title/al certifier	nterM		29c. I	License number	85	29d.	Date signed (Mon	nn, Day, Year)
	V		30. Name an ddress of person who complete SARA L. HOKTON	eted cause of dea	th (Item 23a) (Typer-	Print)	NO E	ROXD	#24( )	ANNAPOLIS	11, Day, Year) 55 5, MD 21401
	Sta Registr	- 145	31. Date filed (Month, Day, Year) MAY 1 8	2005 Hegista	s Signature	Page					

Reisterstown

10f. Zip Code

21136

1 ☐ Yes 2X No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10d. Inside City Limits

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

Baltimore City

USA

14. Race - American Indian, Black, White, etc.

USA

21236

1 Yes 2 No

10c. City, Town or Location

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mental Hygiene.
ant: If Itam 27 is marked other than "natural", or Items 23s or 28s-f show ury or other traumatic event, Ita Medical Examinat must be notified at permit. Pages 1 and 2 Department of Health a Important: if Itam 27 is any Injury or other trat once. Physician

/Medical

For State Registrar

Usual Residence of Decedent

10b. County

1801 Ridge Road

FERNANDO

31. Date filed (Month, Day, Year) MAY 18

1 Never Married 2 Married

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

Baltimore

15. Decedent's Education (Specify only highest grade completed)

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates:

College (1-4or 5+)

10a. State

Md.

11. Marital Status

10e. Street and Number

mpleted by Funeral Director

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Examiner

attending physician and for use as the burial-transit certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Diractor: After thi
completely filled in by the funeral (

5+	Educat	or	Sch	ool System	
1)		18. Mother's Nam	ne (First, Middle, Maiden	Sumame)	
anni		C1o	tilde Nadd	leo	
(Type, Print)	19b. Mailing Address (Stre	et and Number or Rui	ral Route Number, City o	or Town, State, Zip Code	9)
ra/Daughter	1801 Ridge R	oad Reist	erstown, Ma	ryland 211	36
Removal from State	semetery, crematory or other p	nlace)	14		
I Ruels	/				e, Inc.
neligations that caused the deat	h. Do not enter the mode of o	lying, such as cardiac	or respiratory arrest,	Inte	roximate rval Between
CHRONIC	OBSTRUCTIVE	Purmon	may DIS	EMSE YE	et and Death
Due to (or as a conseq	uence of):			of a	
b					
Due to (or as a conseq	uence of):				
C	mence of):			210	0500
d					
On the second of second				001.0.4.4.4.1	
1 ☐ Live birth 2 ☐ Feta	al death 3 □Ectopic pregna				Year
contributing to death but not res	sulting in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to the ca	use of death?
tenosis 142	pertension		11 Yes 2	No 3 ☐ Probably	4 🗌 Unknown
niĝ			24a. Was an	24b. Were autopsy f	indings available
			performed?	death?	
<u></u>		26 Place of Dea		0 10100 20	110
Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Control of the Contro		6 ☐Other (Specify)	
28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury	njury at Work?			
be d 28e. Place of Injury - At h building, etc. (Speci	iome, farm, street, factory, offi iy)	се			ute Number,
Physician: To the best of my known aminer: On the basis of examination and manner stated.	owledge, death occurred at th ation and/or investigation, in n	e time, date and place ny opinion, death occu	a, and due to the cause(s urred at the time, date an	s) and manner as stated ad place, and due to the	cause(s)
	(Type, Print)  ara/Daughter  20b. F.  ara/Daughter  20b. F.  Bulla  20b. F.  Dulla  20b. F.  Dulla  20b. F.  Dulla  20c. F.  Dulla  anser  Dulla  Anser  Due to (or as a consequence)  b.  Due to (or as a consequence)  c.  Due to (or as a consequence)  d.  23c. If yes, outcome of pregnance in the pregnant at time of consequence in	S+ Education   State   Street   Stree	Stanni   19b. Mailing Address (Street and Number or Ru   18th Address (Street and Number or Ru   18th Address (Street and Number or Ru   18th Address (Street and Number or Ru   18th Address (Street and Number or Ru   18th Address (Street and Number or Ru   18th Address (Street and Number or Ru   18th Address (Street and Number or Ru   18th Address of Facility   18th A	Sch   Educator   Sch	School System   School Syste

DHMH 17 Rev 1/2001

State Registrar MA

gistrar's Signature

DARD

BR 170

333	1		1 - For Amend Item 1 p	State of Ma per me G	aryland	d / Depa − <b>19∂0</b> 7	artmen	t of H	lealth a	and M		giene Reg. No.	005	167	703
			Decedent's Name (First, Middle, Last)								2. Date of De.		Yea	3. Time o	of Death
1	Physici /Medio		Daniel R. (	Califano							MAY	13,	2005	1556	Рм
	Examir		4a. Facility Name (If not institution, give str	eet and number)					Location			4c.	County of De	ath	
			SINAI HOSPITAL						E CIT				N/A		
	Funeral		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Ag	e (în yrs. la 19	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da 1 15	th y, Year) TO:	9. B	irthplace (State Country)	or Foreign
	Director		Usual Residence of Decedent								_ 1 13		00	N.C.	
	show		10a. State 10b. County		10c. City	, Town or Lo								10d. Inside (	1
	Ba-fs	cto	PA Cumberla	nd 		Mech	anics	burg						1 XYe	s 2 No
	ith th	Dire	10e. Street and Number				10f. Zip	Code 1705	5			10g. Citi	zen of What		
	s 23e	by Funeral Director	17 Kingswood Dr.	Was Decedent	Eugs in 11 6	12.1				ining (Con	situ Vaa as Na		US.	A nerican Indian,	
	ter de	-un	11. Marital Status 12  1 ☑ Never Married 2 ☐ Married	Armed Forces?			If Yes, spec	offy Cuba	n, Mexicar	n, Puerto i	cify Yes or No Rican, etc.)		Black, Wi		
920	al', or		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1□Yes :	2 <b>/</b> No	Specify:				Specify:	white	
21215-0036	72 hours after deeth with the Maryland natural; or Items 23a or 28a-f show Jisal Ezarra art nust be notified at	Completed	15. Decedent's Educa	tion completed)		16a. Deced	dent's Usua kind of wor	al Occupa	ation during mos	at of working	ng	16b. Ki	nd of Busines	s/Industry	
121	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of wol DO NOT us dent	e retired	0				Eđu	cation	
	illed v Hygie ther t		17. Father's Name (First, Middle, Last)	N/A		500	aenc		18. Moth	er's Name	(First, Middle,	Maiden	Surname)		
an	d be Bntal ked o	To Be		lifano						ea	Coyl		,		
Maryland	12 should be filed within " h and Mental Hygiene. 7 is marked other than " fraumatic event. Ita Med	-	19a. Informant's Name/Relationship (Type	, Print)		19b. Mailir	ng Address	(Street			/ Route Numbe		r Town, State	, Zip Code)	
	alth a alth a 127 is		Pete Califano-fath	ner		17 K	ingsw	boo	Dr. M	lecha:	nicsbur	g, E	PA 170	)55	
ore	iges 1 and 2 should be filled within 72 hours after deeth with the Maryla it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event. It is Medical Expresser into the freditted at		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Rer	noval from State	20b. Pl	ace of Dispo	sition (Nan matory or o	ne of ther plac	e)	D	ate	20c. Lo	cation - City	or Town, State	
Ë	Pag ment ant: i		'4 ☐ Donation 5 ☐ Other (Specify)	novar nom otale	Gat	e of l	Heave	n Ce	m. 5	5/18/	2005	Med	chanics	sburg, F	PA
Baltimore,	permit. Pages Department of Important: if i any injury or one		21. Signature of Funeral Service Licensee	117			2. Name an			MAR	CH FUNE	ERAL	HOME-E	EAST	,
			23a. Part1. Enter the disease, or complica	tions that caused	the death						ue Balt		e, MD	21202 Approxima	ate
	Cinciana .		shock, or heart failure. List only one Immediate Cause (Final			4.4	(T) ( a							Onset and	etween d Death
	/Medical		disease or condition resulting in death)	Due to (or as			TVR	155						-	
	Examiner		Sequentially list conditions h		·										
	P	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a consequ	ence of):									
	death certificate be executed e attending physician and nd for use as the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a consedu	ence of):								-	
8760,	be exician buria			240 10 (01 40	u 0011004u	31100 01).								1	
687	ficate p phys	edicai	d												
Box	leath certific attending p	by Physician/Me	230. Was decedent pregnant	. If yes, outcome 1 □Live birth			∃Ectopic pr						23d. Date of c	delivery	
Θ.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Other (sp						Month	Day	Year
P.O.	at the	Phys	9 Unknown						1211270		oo- Did			A - 10	
	v requires that the de been signed by the should be detached		Part II. Other significant conditions contri	buting to death b	out not resu	iting in the u	nderlying c	ause giv	en in Part i	1.	238. Did t		S	to the cause of Probably 4	
orc	requi	eted											ī		
3ec	e lav has je 2	Completed									24a. Was autop		24b. Were prior t death	autopsy finding o completion of ?	s available cause of
a	ician: The certificate hi rector, page	e Co	25. Was case referred to medical						00.51	(D 1)	1 <b>∑</b> ¥es	2 🗆 No	1, <b>X</b> (Y	es 2 No	
Ξ		To Be	evaminer?	spital: 1 Kinpatie	ent 2 🗆 i	ER/Outpatier	nt 3 DC	)A Oth	or:		<i>(Check only o</i> ne 5 ☐ Resi		6 □Other (Si	necify)	
o	g Physics this seral di		27. Manner of Death	28a. Date of Inju	Irv	28b. Time o		8c. Injun		- 2	28d. Describe	how injur	y occurred		
Division of Vital Records,	Attending I r death. ector: After by the funer	Certification:	1 □Natural 5 □ Pending 2 ◯ Accident investigation	5/8/0		2:26			Yes 2	No F	COLLI		of u		
i	or Atto	rtific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Ini building, et	c. (Specify	me, farm, sti	reet, factory	/, office			City or Tot	wn. State	)	Rural Route Nu	
	urs al		One Codifice 4 Govitato Bt.	ROA		ulade - 1		********		_				FALLS RI	, NU
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edica	29a. Certifier 1 Certifying Physic (Check only one)	r: On the basis o and manner st	f examinat	ion and/or in	vestigation	, in my o	pinion, dea	ath occurr	and due to the ed at the time,	date and	and manner I place, and d	ue to the cause	(s)
	To th Withir To th compl	2	29b. Signature and title of certifier				290	. Licens	e number			29d. Dat	te signed (Mo	nth, Day, Year)	
	188		) lines	)				(	OCME			MAY	14,	2005	
1	O'		30. Name and address of person who com			23а) (Туре,		Litro-	and Cartin	1000	- postavana	170-00-0		96275V796	00000
			ANA RUS		rar's Signat	ure	3.4.	L I C	m St	reet	paiti	HOLE	, Nary	land 21	201
	Sta Registi		31. Date filed (MonWAY 18 200	5	an o digital	k L	and i	-							

		. For	State of Maryland		rtment of Health	•		_	
		1 - State Registrar		Cer	tificate of Death		Reg. No	<u>2005</u>	16704
Physici	an	Decedent's Name (First, Middle, Last)	. 0			2. Date o Month Ma.y		y 005 Year	3. Time of Death 1:35 P M
/Medic	al	1 De RHO 4a. Facility Name (If not institution, give s	L l'amp	bel	4b. City, Town, or Location			JUD c. County of De	
Examin	er	College View C	1	i	Frederick	oi Death	-	Freder	
Funeral		5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year		f Birth	9. Bi	rthplace (State or Foreign Country)
Director		294-10-658 15	M 20XF 88	Yrs.	Months Days Hours	Min. (Month	Day, Year	4 Oh:	
pur M		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	ration				10d. Inside City Limits
Manyli f sho	ō	Maryland Frederick	,	ederic					1 □Yes 2□No
r 28a-	Director	10e. Street and Number	·	edelic	10f. Zip Code		10g. C	itizen of What C	XX
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s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give		☐ Yes 2√√No Specify:	, , , , , , , , , , , , , , , , , , , ,	<b>,</b>	Specify Whi	
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d with	Com	8	College (1-401 37)	Cas	nier Commissa	ry	Fed	leral Go	vernment
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Lai y lattu K. I.K. 2 should be filed with and Mental Hygiene. Is marked other the aumatic event. Itel	2	Norris Burell		7		nel Alice			
pornti. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Maportant: If them 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once.		19a. Informant's Name/Relationship (Ty. Daniel Jones (Gran			g Address (Street and Numbe Hooper Road,				
C, IV	i	20a. Method of Disposition	,	ace of Dispo	sition (Name of place) une	Date	-	ocation - City o	
permit. Pages Department of I Important: If Ite any injury or o		1XXBurial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	emetery, cren	Notice of the place June	16, 2005			Virginia
permit. F Departme Importan any injur		21. Signature of Funeral Service License		22	National Ceme	Mee Funer		_	
a a a a a a	-	1/1/100%	L 10015	3 A	lexandria Ferr	y Rd, Cli	nton.	MD 207	35
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death						Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (or as a consequ	rence of):	1,70				
Lammer	<u></u>	Sequentially list conditions	Due to (or as a consequ						1041)
rted nsit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 to to tas a consequ	ience or).					
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ute be ex nysicien he buria	cal		I						
Untained in by the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director-Alter this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	an/Med	IF FEMALE:	• • • • • • • • • • • • • • • • • • • •		<del></del>				
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The law	mo						iutopsy enformed? es 2 2 N	death?	completion of cause of
Attending Physicien: The advantage of a death. ector: After this certificate his yithe funeral director, page	BeC	25. Was case referred to medical examiner?			26. Place	of Death (Check of		•	
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ding Phys After this funeral di	io i	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		ibe how inju	ury occurred	
death death ctor: , the f	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm str	M 1 Yes 2	-	on /Street a	nd Number or 6	Rural Route Number,
after Direct	Certification;	4  Homicide determined	building, etc. (Specify	)	est, ractory, office	City or	Town, Star	(e)	iarar riobie rioritoer,
To the Hospital or Attendi within 24 hours after death. To the Funeral Directors A completely filled in by the fu		29a. Certifier 1 Certifying Phys	sician: to the best of my know	wledge, death	occurred at the time, date an	nd place, and due to	the cause(	s) and manner a	as stated.
the He in 24 the Fu	Medical	(Check only 2 Medical Examilations)	ner: Of the basis of examinat and manner stated.	ion and/or inv	estigation, in my opinion, dea	th occurred at the ti	me, date ar	nd place, and du	e to the cause(s)
To To Com	Σ	29b. Signature and title of centrier			29c. License number	•	29d. D	ate signed (Mor	nth, Day, Year)
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100		30. Name and address of person who co			) -	PILLS h	11/11	Nill-	mr 110.7
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat		IUM70UN I	riwz, n	- 1) 4	10109	711/2 -1/0(
Registr		MAY 182		K A	nach !				
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 05 · 14 Year VICTORIA CHAMB ERS 4:40 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOSPITAL ARUNDEL ANNE NORTH ARUNDEL GLEN BURNIE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 ☐ M 2 🗗 F 420.36.2842 06.06. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits NIA 1 XYes 2 No BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code CIRCLE 1308 NAUMCAL USA . Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ementary/Secondary (0-12) College (1-4or 5+) 2 YRS CARE PROVIDER CHILD 121H GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MOZNHOD WHOD EMMA ROWE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1308 NAUTICAL CIR. ESSEX MILION GLENN mo. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05.23.05 MI. GODFREY NEWSITE \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BAYD. NAT. PIKE, BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear takens. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) AGE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregran in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 Pending

Examiner Examiner The law requires that the death certificate be executed attending physiclan a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical been signed by the should be detached Completed by page 2 s certificate To the Hospital or Attending Physician: Be Diractor: After this of in by the funeral dire 은 Certification: death. within 24 hours eft To the Funeral Di completely filled in Medical

Physician /Medical

**Physician** 

/Medical

**Examiner** 

Director

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permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene.
Important: If item 27 is marked other then "natural", or itema 23e or 28a-f ehow empiripury or other treumatic event, the Medical Examplest Inual be notified at once.

Baltimore, Maryland 21215-0036

9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?

1 Tes 2 Mo 27. Mann of Death

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

М

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 T Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

N State Registrar

31. Date filed (Month, Day, 1 8 2005

BAL egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY **Physician** 2005 ROSE M. CAMPBELL 16, 7:10 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14 THURKILL COURT COCKEYSVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖺 F 215-44-8687 Director 91 3/24/1914 NEW YORK Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director MD N/A BALTIMORE CITY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5942 GLENNOR ROAD 21239 USA Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: t Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE SECRETARY **IRS** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be fi and Mental F Be and Menta CHARLES WHITE MARIE JANE BOYLAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an Department of Health a Importent: If item 27 Is any injury or other tre once. ROSEMARIE GEHRING/DAUGHTER 14 THURKILL COURT COCKEYSVILLE, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MARY'S CEMETERY 5/19/2005 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a art 1. Enter the disease, or complications that thused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Marleriosekrotic Lindiovisco/sv mmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death signed by the at the detached for 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed Carebro Ysseoler 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s autopsy performed? certificate 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one)

DAUGHTER'S RESIDENCE

4 Nursing Home 5 Residence 6 x ther (Specify) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To the funeral 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funerel C Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and 15504 5/17/05 Dulary Oalley Bid of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day 32. Segistrar's Signature State Registrar

		Please 1	• •		artment of Health ar			egible.	16707
		1 - State Registrar		Ce	rtificate of Death		Reg. No.	000	10/0/
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and and		10a. State 10b. County	10c.	City, Town or Lo	ocation		·-		10d. Inside City Limits
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r 28e	rec	10e. Street and Number			10f. Zip Code		10g. Citiz	zen of What Cou	intry?
h with	a D	6040 Harford Ro	o a d		21214_		USA	4	
ems	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	n? (Specify Yes or I Puerto Rican, etc.)	No- 1	<ol> <li>Race - Ameri Black, White</li> </ol>	
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Shoul nd Me mari	F	19a. Informant's Name/Relationship (7)		19b. Maili	ng Address (Street and Number			r Town, State, Zi	ip Code)
nd 2 s lith an 27 is r treu	1	Stuart T. Camp	bell/Broth	er 376	3 Old Gambler	Road,	Fink	sburg,	Md 21048
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Permit. Pages Department of mportent: If it eny injury or o		21. Signatura i Funeral Strvice Ligen:	\$ <del>00</del>	2	<ol><li>Name and Address of Facility</li></ol>	Wylie F	/H P	.A. of	BaltCO.
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$\gamma$		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)				
7		LOPRAINE OF	n21-AWVAL	1,5801	LOCH RAVEN	BLVD.	BAI	LTIMORI	E, ND 21239
	tate	31. Date filed (Month, Day, Year)	32. Registrar's S		Cook .				

				For State Registrar		State	of Maryl		epartmo Certifica				fental Hy	gieņ Reg. N	71111	5	167	08
				1. Decedent's Nam	ne (First, Middle	, Last)							2. Date of D	eath		Year	3. Time o	of Death
_		Physicia		Joe Brad	y Crain								May 16	, 2	005	Tear	5:35	АМ
		/Medic Examin		4a. Fecility Name (	(If not institution,	give street and nu	umber)		4b. C	ity, Town, o	or Location	of Death		4	lc. County	of Death	-	
		xa		Suburban	Hospita	<b>a</b> 1			Be	thesd	a				Montg	omer	У	
		Funeral		5. Social Security I	Number	6. Sex	7. Age (In	yrs. last birth	day) If Un Mont	der 1 Year	If Unde	er 24 Hrs. Min.	8. Date of Bi (Month, D Jan. 2	rth	r)	9. Birthp	lace (State	or Foreign
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	36	or It	Ę.		ried 2 Marri	If Yes, G	2 🔯 No live		1 □ Ye	s 2 <b>⊠</b> No	Specif	y:			Specify.	TT1. 4	4-	
	Ö	ural',	q p	3 ∐ Widowed	4 Divorced	Year or	Dates:							1.0		wni		
	5	nat	Completed	(Spe	15. Decedent ecify only highes	's Education t grade completed	)	(	ecedent's U Give kind of ife. DO NO	work done	during me	ost of work	king	160.	Kind of Bu	siness/in	dustry	
	12	Mithle Dan Shan	ם	Elementary/Sec	ondary (0-12)	College	(1-4or 5+)				,				I.B.M			
	2	Hygie ther nt.	ပိ	17. Father's Name	(First, Middle,	Last)		A	ccoun	Lant	18. Mot	her's Nam	e (First, Middle	e, Maide	en Sumam	e)		
	anc	ntal led o	Be	Clarence							Day	1000	Kellar			,		
	Ž	d Me d Me mark matic	ဥ	19a. Informant's N		nin (Tune Print)		19h 1	Mailing Add	ess (Street			ral Route Numi		v or Town	State. Zit	Code)	
	Maryland 21215-0036	12 sl h an 7 ls r treur	1 3	Robert W		, , , , ,	tner		-				ashingt				0000)	
	e,	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28e-f ehow other treumatic event, the Medical Examiner must be notilised at		20a. Method of Dis				Oh. Place of [	Disposition /	Name of			Date		Location -		own, State	
	Baltimore,	tof Filter		1 🗆 Burial 2	☑ Cremation	3 Removal from	n State	cemetery.	crematory	or other pla J	ice)	May	17,	-			5-734	
	Ħ	rtmer rtant rtant		`4 ☐Donation 21. Signature of F	5 Other (S)			remato	rium,	Inc.		2005	ert A.	Pum	thesd phrev	a, M Fun	arylaı eral İ	nd Home/
	Ba	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of P	1	17/	_ MON	0689	Bethe	esda-(	Chevy	Chas	se, Inc	. 75	557 Ŵ:	isco	nsin A	venue
			$\vdash$	23a. Fart 1 Enler	the disease, or	complications that only one cause on		1	t enter the	node of dy	ing, such	y Landas cardiac	d 20814 or respiratory	arrest,	U.L.		Approxima	ite
				Immediate Cause		only one cause on	each line.										Interval Be Onset and	Death
		Physician /Medical		disease or conditi	ion		eumonia									-		
10		Examiner	П					nsequence of	):									
90191			ē	Sequentially list of	onditions,		edamoi o (or as a cor	nas nsequence of	):							_		
01		ted nsit	Examiner	Sequentially list c if any, leading to cause. Enter Und that initiated even	derlying or injury	<b>S</b>												
٧,		be executed sician and burial-transit	xai	resulting in death	ts ) Last	c. Due to	o (or as a cor	nsequence of	):									
	68760	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	dicai F															
N	89	ficate I g physi	edic			V									111-1	-		
	Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decede	ent pregnant	23c. If yes, o									23d. Dat	e of deliv	ery	
K		atte	clai	in the past 1	2 months?	4□Preg	birth 2 🗌 gnant at time		3 ∐Ectop 5 ☐ Othe	c pregnance (specify) _	:y				Mor	nth	Day	Year
	0	res that the de igned by the a be detached t	nysi	9 Unknow		9□ Unk	nown											
05)	σ.	that thed by deta	by P	Part II. Other sign	nificant condition	ons contributing to	death but no	t resulting in	the underlyi	ng cause gi	ven in Pa	t I.	23e. Did	tobacc	o use conti	ribute to t	he cause of	death?
U	ds	puires n sign	q p	Renal Fa	ailure_								1 🗆	] Yes	2□No	3 🏻 Pro	oably 4 🛣	]Unknown
	Records,	w require been signal	Completed										24a. Wa		24b. \	Vere auto	psy findings	s available
1	Re	he faw s has ge 2 s	m d	-									per	opsy formed	?   0	leath?	mpletion of	cause of
On	Vital	ician: The certiticate har rector, page	e C	25. Was case refe	orred to madical	7-1				170 7	ae Die	oo of Doa	1 ☐ Yes		No   I	Yes	2L No	
0	₹	sicia	o Be	examiner?		Hospital:	Inpatient	2 ER/Out	nationt 2	DOA O			ome 5□Re	7 777	6 □Oth	or (Snani	64)	
~	of		H-1	27. Manner of De	_	-	e of Injury onth, Day Yes		me of	28c. Inju		Nuising 11	28d. Describe				97	
5	ū	ding h. Afte fune	ţ	1 X Natural 2 ☐ Accident	5 Pendin investig	9	onth, Day Ye	ar) In	ury M		ork? ]Yes 2	□No						
. >	Division	l or Attencatter death Director:	lica	3 🗌 Suicide	6 Could	not be	ce of Injury -	At home, fare	m, street, fa	ctory, office	)		28f. Location	(Street	and Numb	er or Rur	al Route Nu	mber,
rain	ο	atter Dire	Certification:	4 🗌 Homicide	determ	buil	lding, etc. (S	(pecify)		*			City or T	own, St	ate)			
7		Hospitel or Attending 24 hours after death. Funeral Director: After tely tilled in by the fune		29a. Certifier	1√∑ Certifyin	ig Physician: To ti	he best of my	y knowledge,	death occu	red at the t	ime, date	and place	, and due to th	e cause	e(s) and ma	nner as	stated.	
		To the Hospitel or Attendi within 24 hours atter death. To the Funeral Director: A completely tilled in by the fi	dical	(Check only one)		Examiner: On the												(s)
_	_	To the vithin 2 To the comple	Z	29b. Signature ar	title of dertifie	r				29c. Licer	se numbe	r		29d. [	Date signe	d (Month,	Day, Year)	
		I.		<b>)</b> ///	111					D 6	1302			Ma	ay 16	, 20	05	
	\ \	0		30. Name and ad	dess of person	who completed ca	use of death	(Item 23a) (1	ype, Print)									
		$l_{\odot}$			/	4.D., 860				Road	, Bet	hesda	a, Marv	1an	d 208	14		
		⊕ Sta	ate	31. Date filed (Mo	onth, Day, Year)	32.	Registrat's	Signature										
		Regist			MA	Y 1 8 2005	Head	wa h	Y A	rode	)							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Reg.	No.	U	U	1
_		_					

16709

			1. Decedent's Name (First, Midd	le, Last)					2. Date of De			3. Time of Death
	Physici /Medio		Margaret Frances Coleman						May 14, 20		005	12:48 A N
	Examir		4a. Facility Name (If not institution, give street and number)				4b. City, Town, o					
			Suburban Hospital				Bet	hesda		N	lontgo	mery
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birth	place (State or Foreigntry)
	Director		578-14-3473	1 □ M 2 🕅 F	87	Yrs.	Working Days	1,0013	Jan. 3,	1918	Wash	ington, D.C.
	D >		Usual Residence of Decedent  10a, State 10b, County		10c Cit	y, Town or Lo	vention				Т.	10d. Inside City Limits
	anyla shov	_		•								1 ☐ Yes 2X No
	8a-1	cto		omery	Ве	ethesd						
	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o		
	ath v	Ta	9707 Old Georg				208				d Sta	
	er de	nue	11. Marital Status	Armed F		S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	)- 14. Ha	ace - Ameri ack, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, I'm Marical Eparities must be putilled at ODGs.	by Funeral	1 ☐ Never Married 2 ☐ Mar 3 🖫 Widowed 4 ☐ Divorced	If Yes G	2∭ No ive		1 ☐ Yes 2X No	Specify:		Spec	ity: Whi	lte
ô	hour tural	pa		nt's Education	Ja163.	16a Dece	dent's Usual Occup	nation		16b. Kind of	Business/In	dusta
5	n 72	Je t	(Specify only highe	st grade completed		(Give	kind of work done DO NOT use retire	during most of work	ing	TOD. KING OF	Du31110334111	oustry
12	withi ene. then	Completed	Elementary/Secondary (0-12)	Elementary/Secondary (0-12)   College (1-4or 5+)						Own Home		10
2	Hyg Hyg ther	Ö	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle	le, Maiden Sumame)		
an	d be ental	To Be	John Campbell	l Jett				Eli:	zabeth :	McClel1	ellan	
2	marl marl	F	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	na Address (Street	and Number or Rur	al Route Numb	er. City or Tow	City or Town, State, Zip Code)	
Maryland 21215-0036	d2 stharthartharter		James R. Cole					Gate Ter				20854
	Hea Hea tem		20a. Method of Disposition		20b. F	lace of Dispo	sition (Name of		Date	20c. Location		
Baltimore,	ages int of t: If I		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State		matory or other pla	ray =		211		
Ħ	it. Partme		21. Signature of Funeral Service		Gat	2:	eaven Cemet	ass of Facility			0.0	Maryland
Ва	Depa Impo any ii		Milliam a	1) 1/	M01	Ro	obert A. Po	umphrey Fun onsin Ave	eral Home	e, Bethes	da-Che Marv	vy Chase, In land 208
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	caused the deat							Approximate Interval Between
	Enysician	89 Y	Immediate Cause (Final disease or condition	5	TROI							Onset and Death
7	/Medical		resulting in death)	a Due to	(or as a conseq							5 6/17
п	Examiner		Conventingly list conditions	b								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):						
	cuted	Examiner	cause. Enter Underlying that initiated events	С.								
o,	e exe		resulting in death) Last	Due to	(or as a conseq	uence of):						
376	ate be nysici	cal		d							_	
99	ng ph	Jed	IF FEMALE:									
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	an/Medical	23b. Was decedent pregnent		utcome of pregna birth 2 Feta		Ectopic pregnanc	v			ate of deliv	ery Dav Year
	e dea he at ed fo	75	in the past 12 mounts? 1 □ Yes 2 ☑ No	4☐ Preg 9☐ Unki	nant at time of d	eath 5	Other (specify)			,	AGITTI)	Day Fear
P.0	The law requires that the de ate has been signed by the a bage 2 should be detached t	Physic	9 Unknown						00. 011			
Ś	ignex bed	by	Part II. Other significant conditi	PHOM	death but not res <b>4</b>	uiting in the u	nderlying cause gr	ven in Part I.		_ /		he cause of death?
ord -	w requir been si should	ted	1/17	MON					1 🗆	Yes 2 No	3   Proi	bably 4 Unknow
Records,	e law r has be	Completed							24a. Was auto	psv	. Were auto	opsy findings available impletion of cause of
R	The ate h page	200							perfo 1 ☐ Yes	ormed? 2☐₩6	death? 1 🗌 Yes	2 No
Vital	ding Physician: The h. A. After this certificate his funeral director, page	Be (	25. Was case referred to medical examiner?		_			26. Place of Deat	h (Check only	one		
of V	nysic li dire	2	1 □ Yes 2 □ 110	Hospital: 17	Inpatient 2	ER/Outpatie	nt 3 DOA Ot	her: 4 🗆 Nursing Ho	ome 5 Resi	idence 6 🗆 O	ther (Speci	fy)
	ng Ph ter th		27. Manne of eath 1 atural 5 Pendi	28a. Date (Mo.	of Injury nth, Day Year)	28b. Time of Injury	f 28c. Inju Wo	ry at	28d. Describe	how injury occi	urred	
O.S.	Attending Physician: r death, sctor: After this certifica by the funeral director.	atl	2 Accident invest	igation				Yes 2 □ No				
Division	r Attencter death	ertiflcation;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	mined 288. Place	e of Injury - At he	ome, farm, st	reet, factory, office			Street and Nur wn, State)	nber or Run	al Route Number,
	Hospital or Attended     Hours after deatle     Funeral Director: etely filled in by the	Cer										
	Hospital 24 hours a Funeral I	edical		ing Physician: To the								
	n 24 n 24 ne F	b	one)	and ma	nner stated.			.,				1-1

State Registrar

DHMH 17 Rev 1/2001

30/eman, Margaret F. 5/14/05 12:48 am

		•	1 - For State of Maryland Registrar		artment of H		F	Reg. No. UUS	16710
	Physici /Medic		Decedent's Name (First, Middle, Last)     NAICHIA MOORE CARTER				2. Date of Dea Month MAY 1.		3. Time of Death 10:11 PM
- Aria	Examin	er	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MD SHOCK TRAUMA		4b. City, Town, or BALTIMO	ORE CIT	TY	4c. County of Deat	
	Funeral Director		5. Social Security Number  217 - 98 - 7272    Usual Residence of Decedent   6. Sex   1   M 2   XF   23	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Day	h y, Year) 9. Birt Co 10,1981	hplace (State or Foreign untry) MD
	faryland show	or	10a. State 10b. County 10c. City	, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the Maryland is or 28a-f show	Director	10e. Street and Number	ALTIM(	10f. Zip Code	1.7		10g. Citizen of What Co	untry?
	ems 23s	Funeral	1610 N. GILMOR STREET  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	3. 13.	Was Decedent of H		n? (Specify Yes or No- Puerto Rican, etc.)	USA - 14. Race - Ame Black, White	
9000	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dical Examinat must be nodified at	þ	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:	,	Specify: BI	LACK
21215-0036	- 3	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most o d)	f working	16b. Kind of Business/	Industry
d 21	filed within Hygiene. other than "	e Con	11 17. Father's Name (First, Middle, Last)	DEOI	OORANT BL		KER Name (First, Middle,		DEODORIZING
Maryland		To Be	MOSES CARTER				NNE MOORE	O: T O:	T. O. (1)
	マモトラ		19a. Informant's Name/Relationship (Type, Print)  CLEADER WARREN/GRANDMOTHER	1	O N. GILM			er, City or Town, State, 2 CE, MARYLANI	
nore	ages 1 ant of He tr. If item y or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	metery, cre	osition (Name of matory or other place CEMETER)		Date 1AY 18,05	20c. Location - City or	
Baltimore,	permit. Pages 1 am Department of Healf Importent: If item 2 any injury or other 2008.		21. Signature of Funeral Service Licensee	22	2. Name and Addres	ss of Facility	JAMES A. I		, MARYLAND NS F.H., INC. LAND 21217
	. 11		23a. Part Enter the disease, or complications that caused the death shot, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
1	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a	ound ence of):	to back				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):					
0,	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of the consequence of th	ence of):					
68760,	titicate be ng physici as the bu	edical	d						
P.O. Box	Attending Physician: The law requires that the death certificate be executed refeath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3[	□Ectopic pregnancy □ Other (specify)	′		23d. Date of del Month	ivery Day Year
	quires that in signed t uld be det	by	Part II. Other significant conditions contributing to death but not resu	Iting in the u	inderlying cause giv	en in Part I.	23e. Did t	obacco use contribute to Yes 2 ⊠No 3 □ Pr	the cause of death?
Vital Records,	The taw requir ate has been s page 2 should	Completed					24a. Was autor perio 1 Ves		utopsy findings available completion of cause of 2 \( \subseteq \text{No} \)
	ysician: The is certiticate hadirector, page	To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  Hospital: 1 Inpatient 2 X	ER/Outpatie	nt 3 DOA Oth	or	of Death <i>(Check only o</i>	one) dence 6 □Other (Spe	cify)
o uc	ding Phys h. After this funeral di	tion; T	27. Manner of Death 1 □ Natural 5 □ Pending (Month, Day Year)	28b. Time o	of 28c. Injur Wor	yat k? Yes 2 XÎN	e 1	how injury occurred	
Division of	To the Hospitel or Attendivitin 24 hours after death. To the Funerel Director: A	Certification;	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, st			28f. Location (:	Street and Number or Ri wn. State)	Bathmar HD
)	Hospite 24 hours Funerel	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Exeminer: On the basis of examinat and manner stated	wiedge, deat	th occurred at the tire	me, date and opinion, death	place, and due to the	cause(s) and manner as	s stated.
	To the within To the comple	Me	29b. Signature and title of certifier	10	29c. Licens			29d. Date signed (Mont	
1	11		30. Name and address of person who completed cause of death (Item	23a) (Type	Print) 111 Penn	Stree	t Raltimo	ore, Maryla	
		ate	31. Date filed (Month, Day, Year)  32. Registrar's Signat	ure	Carlo D		- DOLL GLIR	, imity tal	21201
	Regist	rar	MAY 1 8 2005 Manager 2	G Fa	The same of the sa				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. state of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND ITEM #5 PER FH G844 64061105 at 1940 f Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year Day Month

3. Time of Death

Physician	
/Medical	
Examiner	

**Funeral Director** 

28a-f show ō 72 hours after death 2 should be filed within and Mental Hygiene. permi. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic events.

**Physician** /Medical Examiner

P.O. Box 68760, Records, Division of Vital death. within 24 hours a To the Funaral C

400 Bauers Drive 21040 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2√ Married 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15 Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter 6 17. Father's Name (First, Middle, Last) Moody Coleman Mandy Coleman 19a. Informant's Name/Relationship (Type, Print) Wanda Coleman /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill 5/18/05 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee 3a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Immediate Cause (Final phicemia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a conseque (ce of): Kon te Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy perform 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 € No 28c. Injury at Work? 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier and manner stated 29b. Signature and title of certifier

0305M 5, 2005 Herman B. Coleman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death -35-1925 Birthplace (State or Foreign Upper Chesapeake Hospital Falston 8. Date of Birth (Month, Day, Y If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Days Hours Months 1⊠M 2□F 79 Yrs. Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Harford Edgewood Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.a. Funeral 14. Race - American Indian, Black, White, etc. Specify: White þ Completed 16h Kind of Business/Industry Constuction Vehicles 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Bauers Drive Edgewood, Maryland 21040 20c. Location - City or Town, State Baltimore, Maryland 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair koad baltimore, Maryland\_21206 Approximate Interval Between Onset and Death Clammatory Response Syndrome Physician/Medical 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 20 No Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28d. Describe how injury occurred Certification: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year)

State

Registrar

32. Registrar's Signature

602 S. ATWOOD Rd, #205, BELADR, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANGELO

MAY 1 8 2005

31. Date filed (Month, Day, Year)

		•	State of Maryland / Department of Health and Mental Hygiene 15   57   2   57   2   57   2			
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Edmund Dieh 2. Date of Death May 16th 2005 7.15 pm  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death 4c. County of Death			
	Funeral Director		Stella Maris  5. Social Security \$7979 188-03-9920  6. Sex 10 Months   Timonium   Timonium   Baltimore   State or Foreign   Months   Days   Hours   Min.   Dec. 29, 1919   PA			
	Maryland e-f show	ctor	Usual Residence of Decedent  10a. State			
	eeth with the	Funeral Director	10e. Street and Number 1025 Adock Road 10f. Zip Code 21093 10g. Citizen of What Country? USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-			
9003	i within 72 hours atter deeth with the Maryland liene. r than "natural", or Items 23e or 28e-f show The Macical Evarinar must be notified at	þ	Armed Forces?  1 Never Married 2 Married   Armed Forces? 1 Never Married 2 Married   M			
21215-		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Engineer Railroad			
yland	should be filed and Mental Hygis s marked other umatic event, II	To Be (	17. Father's Name (First, Middle, Last)  Charles Lawerence Diehl  18. Mother's Name (First, Middle, Maiden Sumame)  Alma May Doll			
e, Mar	t and 2 dealth a em 27 ls		19a. Informant's Name/Relationship (Type, Print) Rebecca Diehl/wife  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1025 Adock Road Lutherville, MD 21093  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State			
Baltimore, Maryland 21215-0036	permit. Pages Department of I Importent: If it any injury or o		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)  4 Donation 5 Other (Specify)  4 Donation 5 Other (Specify)  4 Donation 5 Other (Specify)  4 Donation 5 Other (Specify)  4 Donation 5 Other (Specify)  5 Contain 1 Ruck Towson Funeral Home, Inc.			
	Physician		S. Coster 1050 York Road, Towson, MD 21204  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between onset and Death disease or condition  a. Previous Cause (Final disease or condition)			
8760, €	requires thet the death certificate be executed  seen signed by the attending physician and hould be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Disease) of the Vinta initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):			
.O. Box 6	thet the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			
Vital Records, P.	s L	by	by		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy  24b. Were autopsy findings available prior to completion of cause of
ital Re	The ate has page	Be Com	performed?   death?   1   Yes 2 🕅 No   1   Yes 2 🖾 No   25. Was case referred to medical evanuer?   26. Place of Death (Check only one)			
of	vtending Physicien: death. ctor: After this certific y the funeral director,	2	1   Yes 2   No			
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)			
	the Hosp hin 24 hor the Fune mpletely fi	Medical	29a. Certifier  (Check only one)  18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)			
			29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	12+1	ate	ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093  31. Date filed (Month, Day, Year)  32. Registrar's Signature			
DH	Registi	rar	MAY 1 8 2005 Recent to freely			
			ORIGINAL			

EDMUND DIEHL MAY 16, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 1 2

		1 - State Registrar AMON) TIPM #1 P	State of Maryland / D FR FH C843 5/26/05 J	epartment of Health and I Fertificate of Death	Mental Hygier Reg. N	1000 10710
Physic	an	1. Decedent's Name (First, Middle, Last)	JOSEPH ANIHONY DO			Day Year 3. Time of Death
/Medi	cal	7,0770109	- Joseph	DONATEEL	MAYI	7 2005 4:05 AM
Examir	ner	4a. Facility Name (If not institution, give s  BALT more VI	A 1+050:4AL	4b. City, Town, or Location of Death	2	Ac. County of Death
Euparal		5. Social Security Number 6. Sex		day) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	
Funeral Director		212-34-1216	IM 2□F 68	rs. Months Days Hours Min.	May 30, 193	6 Maryland
pu ,		Usual Residence of Decedent	10c. City, Town	out continu		10d. Inside City Limits
anyla shov	٦	10a. State 10b. County Maryland Balt	imore Baltimo			1 ☐ Yes 2 ☑ No
the M 28a-f	ecto	10e. Street and Number	JAT OTTE	10f. Zip Code	10g. (	Citizen of What Country?
with Sa or	2	19 North Hawthorne Roa	d	21220	US	·
death ms 23	Funeral Director	11. Marital Status	12, Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,
iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinatorial by multified at	b	1 ☐ Never Married 2(X) Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.  Specify: White
72 hou	Completed	15. Decedent's Educ (Specify only highest grade	cation 16a. I	Decedent's Usual Occupation (Give kind of work done during most of wor	king 16b.	Kind of Business/Industry
within 7 ene. than "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		
filed wi Hygien other th	Co		2 Se	elf Employed		ructural Detailers Inc.
id 2 should be file th and Mental Hy 27 Is marked oth traumatic event	Be	17. Father's Name (First, Middle, Last) Alfred F. Donatelli			ne (First, Middle, Maid	en Surname)
2 should be and Mental Is marked aumatic ev	P L	19a. Informant's Name/Relationship (Ty)	na Print) 19h	Gertrude ( Mailing Address (Street and Number or Ru		v or Town State Zin Code)
d 2 s th an trau		Linda B. Donatelli-Wife			Itimore Mary	
Health tem 27 other tre		20a. Method of Disposition	20b. Place of	Disposition (Name of crematory or other place)		Location - City or Town, State
ages ent of rt: If i		1 🕅 Burial 2 □ Cremation 3 □ R  `4 □ Donation 5 □ Other (Specify)		of Faith 5/20	)/05 Ba1	timore Maryland
permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.		21. Signature of Funeral Service License	∞ Christina L. Hilto	n 22. Name and Address of Facility Leonard J. Ruck, Inc.		J
permi Depa Impo		I Christina C	R. Welton	5305 Harford Road Bal	timore Marvla	and 21214
flicate be executed / Medical Examiner / Medical Examiner is the purial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of	RENAL PAILL	ire	
The faw requires that the death certifical the faw requires that the death certifical ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 4  Pregnant at time of death 9  Unknown	3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
es that igned by be deta	by Pr	Part II. Other significant conditions cor	ntributing to death but not resulting in	the underlying cause given in Part I.		o use contribute to the cause of death?
w require been sig should b					1 2 Yes	2 No 3 Probably 4 Unknown
The law requires t ate has been signe page 2 should be	Completed				24a. Was an autopsy performed	
	0	25. Was case referred to medical		26. Place of Dea	th (Check only one)	NO TELITOS ZELINO
99	0.0	examiner? 1 ☐ Yes 2 ⊉No	lospital: 1 ☑ Inpatient 2 ☐ ER/Out	Other	ome 5 Residence	6 ☐Other (Specify)
ling After une	tlon; T	27. Manner of Death  1. Matural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b. T	ime of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	njury occurred
I or Attending after death. I Director: After din by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	edical C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the cause irred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
o the ithin i	Med	29b. Signature partitle of certifier	and marmor stated.	29c. License number	29d.	Date signed (Month, Day, Year)
₽ <u>₹ ₹ 8</u>		1 13.1	7.11	P17646		5-17-05
.1.1		30. Nam and address of erson who co	ompleted cause of death (Item 23a) (	Type, Print)	7	
1011		BRIGIT TA	YLUR MD	Type, Print) GREENE St	Reet DAL	timure, MB 21201
St	ate	31. Date filed (Month, Manyear) 8 2	005 32. Agistrar's Signatur	South		
Regist	rar		MURCURU JO	The same of the sa		

			1 - For State Registrar	State of Marylan	nd / Depart		lealth and M	1ental Hygi	g. No		16714
	Physici /Medio		Decedent's Name (First, Middle, Last)     RICHARD	ELLSWORTH	DECORS	E		2. Date of Death	, Da 200	5 <sup>Year</sup>	3. Time of Death 10:04p M
	Examir		4a. Facility Name (If not institution, give st GREATER BALTIMOR	reet and number) E MEDICAL	CENTER		r Location of Death TOWSON		ВА	y of Death LTIM	
	Funeral Director		213 10 2103 1	7. Age (In yrs. 64		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/13/	1940	Cour	place (State or Foreign http:/ YLAND
death with the Maryland	Maryland a-f show	tor	Usual Residence of Decedent		ty, Town or Locat					1	1 Od. Inside City Limits 1 ☐ Yes 2 🛣No
	h with the	al Director	10e. Street and Number 824 E. PINEY HI	LL ROAD		10f. Zip Code	21111	10	og. Citizen of USA		ntry?
		by Funeral	11. Marital Status 1 1 Marned 2 Marned 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		s Decedent of Hes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	ce - Americack, White,	etc.
0-6171	filed within 72 hours atter Hygiene. ther than "natural", or fis ont, the Medical Examina	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation com <i>pleted)</i> College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOTUse retired) FARMER		16b. Kind of Busines FARMII			•	
Ĕ		To Be Co			, ,	st, Middle, Maiden Sumame) E • EVANS					
, Mary	s 1 and 2 should t Health and Men itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type ED DECORSE	brother	901 M	APLEHU	and Number or Rui	E MONKT	ON, M	ID 21	111
Baltimore	permit. Pages 1 Department of H Important: If its any injury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Litense	LO		PARK lame and Addre	MAY 10 ss of Facility HE YORK RO	6, 2005 NRY W.	JENKI	LAWN NS &	, MD SONS CO
н	Physician /Medical Examiner		23a. Part1. Enter the diseas, or complice shock, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the deal e cause on each line.  Due to (or as a consec	ute n		ng, such as cardiac	/	i	1	Approximate Interval Between Onset and Death
5U, be executed	ficate be executed 3 physician and as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec							
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ב.	law requires that the de as been signed by the a 2 should be detached t	d by Phy	Part II. Other significant conditions con	tributing to death but not res	sulting in the und	erlying cause giv	en in Part I.		pacco use cor	ntribute to th	he cause of death?
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Ita	clan: ertifica ector, l	Bec	25. Was case referred to medical examiner?		-			th (Check only on	θ)		
	Physician: The la rthis certificate har ral director, page 2	To.	1 Tes 2 No		ER/Outpatient 28b. Time of	3□ DOA Ott	4 Li Nuising H	ome 5 Reside			<del>(y)</del>
0	ding th. : After tuner	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk? Yes 2 □ No		,,,,,		
Division of	al or Attending Ph s atter death. II Diractor: After th ed in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stree	t, factory, office		28f. Location (St. City or Town		ber or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (	(Check only and Medical Exemination)	ician: To the best of my known:  On the basis of examination and manner stated.		stigation, in my o	ppinion, death occur	red at the time, da	ate and place	, and due to	o the cause(s)
)	or with	8	9b. Signature title of certifier	mon 1	19	29c. Licens	3156	(	9d. Date sign	-20	05
	HT.		30. Name and ddress of person who co  Joh S 7 M  31. Date filed (Month, Day, Year)	mpleted cause of death (Ite  M  32. Registrar's Sign	m 23a) (Type, Pr 5 4 Sco	7+ Ad	am Rod	d cocke	ysville	MP	21030
	St	ate	S. Date mes (mornin, Day, 1 bar)	JE. Hogistiai 3 Jigii							

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITHM #5 PER EH C843 5/26/05 Settificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Daphne Maude Duerbeck Year **Physician** 05 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Ba Himore (enter Kosedak H65pital If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Windsor England 7. Age (In vrs. last birthday) f Under 1 Year 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** Min. Days Hours 1 □ M 2 😾 F Director 19,1925 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b County If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinational De notified at 1 ☐ Yes 2 No Essex Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21221 Funeral 332 Margaret Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 Never Married 25 Married 1 ☐ Yes 2XXXIII If Yes, Give Year or Dates: Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than " Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Lucy Wilson 2 William Edward Eden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Husband 21221 332 Margaret Avenue Essex, Maryland Mr. Frederick J. Duerbeck, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Towson, Maryland Hilltop Service Corp. 5/18/2005 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Week Hureus Priysician /Medical Due to ( r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner as the burial-transit that initiated events ре ехесп resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 🗆 No 3 Probably 4 Unknown 1/X Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2. No To the Hospital or Attending Phystcian: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 27. Manner of Death Injury at Work? Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

uer beck.

State Registra 29b. Signature and title of

. Name and address of person who

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Kamlu 31. Date filed (Month, Da

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(Item 23a) (Type, Pnnt)

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29c. License numbe

hin Square

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of M	larylan		artmeni rtificate			and M	ental Hy	giene Reg. No.		da
	Physici /Medic		1. Decedent's Name (First, Middle, Rosa W. Egan	Last)							2. Date of De Month May 14	Day	7 Year	3. Time of peath 9:05A M
	Examin		4a. Facility Name (If not institution, of Montgomery Hosp			2	Rocl	kvil				1	County of De	nery
	Funeral Director		5. Social Security Number 136–24–3948 Usual Residence of Decedent	. Sex 7. A 1 □ M 2 💢 F	ige (In yrs.	last birthday) O Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Feb. 1	th ay, Year) 4, 1	9. B 925 Pe	irthplace (State or Foreign Country) nnsylvania
	the Maryland 28a-f show	Director	10a. State 10b. County  Maryland Montgo  10e. Street and Number	mery		y, Town or Lo	10f. Zip	Code			•	10g. Cit	izen of What (	10d. Inside City Limits 1 ☐ Yes 2 ☑ No Country?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23s or 28a-f show other traumatic event, the Medical Evarinat must be notilised at	by Funeral	8709 Sleepy Hol  11. Marital Status  1 Never Married 2 Married 3 🛣 Widowed 4 Divorced	12. Was Deceder Armed Forces	? ] No		-	ify Cuba	spanic Ori n, Mexicar Specify:	i, Puerto I	cify Yes or No Rican, etc.)		Black, Wh Specify:	nerican Indian,
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Maryland 21215-0036	should be filed vand Mental Hygies marked other tumatic event, ID	To Be Co	17. Father's Name (First, Middle, La Charles Warner			Home	emakeı	ſ			(First, Middle		Own Hon Sumame)	ne
	1 and 2 should be Health and Mental Iem 27 Is marked of other traumatic even		19a. Informant's Name/Relationship Charles Thomas E			504	Bosto	n A	and Numbe	er or Rura Tal	Route Numb		r Town, State	. Zip Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		20a. Method of Disposition  1  Burial 2 Cremation 3  4  Donation 5 Other (Spe  21. Signature of Funeral Service Lie	cify)	• Mon Cre	Place of Dispondent Commentary, creating of the comment of the com	osition (Nameratory or or or or or or or or or or or or or	ne of ther plac nc. d Addres	e)	May 2 2005 V Robe	ert A.	Bet Pump Mont	hesda,	or Town, State  Maryland  Juneral Home/ Avenue
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P.O. Box 68	he death certific the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3[	□Ectopic pr □ Other (sp						23d. Date of d Month	lelivery Day Year
	w requires that to been signed by should be detac	by	Part II. Other significant condition  Cor Pulmonal	•	but not res	ulting in the u	nderlying c	ause give	en in Part I		1			to the cause of death?  Probably 4 X Unknown
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Division of Vital Records,	To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	tlon; To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 □ Pending 2 □ Accident investiga	Hospital: 1 ☐ Inpa  28a. Date of Ir (Month, L		ER/Outpatier 28b. Time o Injury		8c. Injun	er: 4□Ni	ırsing Hor	(Check only ne 5 ☐ Res 28d. Describe	idence		pecify) Hospice
Divisi	i i ite	Certification;	3 Suicide 6 Could no 4 Homicide determin	t be 28e Place of I	njury - At ho etc. <i>(Specif</i>	ome, farm, sti ý)	reet, factory	r, office		2	28f. Location ( City or To	Street ar wn, State	nd Number or	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral i completely filled	Medical (	(Check only 2 Medical Ex	Physician: To the best raminer: On the basis and manner	of examina	wledge, deat ation and/or in	vestigation	, in my op	oinion, dea	d place, a	and due to the ed at the time,	date and	d place, and d	ue to the cause(s)
<b>;</b>	To To To Com	2	29b. Signature and title of equiller	the				License	112	18		29d. Da	te signed ( $Mo$ ) $5/4$	nth, Day, Year)
1	Sta	ite	30. Name and address of person with the Charles Harrians. 31. Date filed (Month, Day, Year)	·	6001	Muncs	ecter	Mil:	l Roa	d, Ro	ockvil]	Le, N	/ Marylar	d 20855
	Regist	ar	i.a.	NY 1 8 2005	die	مر معرد	1. 1.	-						

amend item#12, perFH, G844, 6/10/05 TI

State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Death

1- State of Maryland / Department of Death

Registraramend item#20b, perFHG844, 6/15 por idate of Death 1. Decedent's Name (First, Middle, Last) Alfred Futtrell 2. Date of Death Val Year 320 AM **Physician** 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 548 West Himore Strea Baltimor If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1 M 2 □ F Yrs. 212-30-2061 06-19-Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, I'm Medical Exantirer must be notified at 1 Yes 2 □ No Completed by Funeral Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number USA. DALTIMORE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 → No 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) DRIVER (UKWOWN) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (UN KNOWN) WILKEMENIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) RIDING CROPWAY, BALTO, MD 21244 KIMBERLY BARBOUR GRANDDAUGHTED 2241 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Øsurial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST 00 23 05 OWINGS MILLS, MD. ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2140 North Fulton Avenue 21217 21. Signature of Funeral Service Licensee any ir Seph H. Brown Jr. Funeral Home Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OVO NAVY embo US **Physician** /Medical **Examiner** rterisclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hypertensim attending physician and for use as the burial-transit MAN GNANT Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Physi 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ cell 3 Probably 1 ☐ Yes 2 ☐ No 4 DUnknown Completed Topna ceo us 9007 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Cluster herdaches 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 After this 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: To the Hospital or Attanding I within 24 hours after death. To the Funaral Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number D18846 eath (Item 23a) (Type, Print) 30. Name and address Paul Man Sutc 509 Brown 301 marsha Registrar's Signature 31. Date filed (A State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** May 17, 2005 0453 MAry E. Fitz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HArford Belair UpperChesapeakeMedicalCenter If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Maryland 1 ☐ M 2 🖫 F 71 Yrs. June10,1933 Director 212-30-2510 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State r Items 23a or 28a-f show iliter is ust be notified at 1 ☐ Yes 2 X No MD Harford Belcamp Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21017 USA 4400 Sanford Court 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married SpecifyWhite 1 ☐ Yes 2 ☑ No Specify: þ 3√3Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore, Maryland 2121 Sewing Elementary/Secondary (0-12) College (1-4or 5+) Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Helen Stansbury Joseph Carrigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is 555 GravsCreekRoad Pasadena MD Gordon Ayres /son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
HollyHillCemetery 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 5/20/05 Injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death formot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Heart Disease Pnysician Ischemic /Medical Due to (or as a consequence of): **Examiner** Renal Failure Sequentially list conditions, if any, issuing to immissible cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a notisequence of) Examiner certificate be executed burial-tran Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ivision of Vital Records, þ 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 VInpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide thin 24 hours a the Funeral D 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai npletely (Check only one) within 29d. Date signed (Month, Day, Year) 29c. License number 0 D0059387 30. Name and address of person who com whed cause of death (Item 23a) (Type, Print) 2 Colgate Drive, Ste. 203, Forest Hill, MD 21050 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

062305

			1 - For State Registrar	State of Marylar		nent of He			ene 0 0 5	16720
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Ralph Eugene F				2	2. Date of Death Month	Day Year 16 200	3. Time of Death
	Examin Funeral Director		102 22 1773	ARE HOSDI	last birthday) If	City, Town, or L ROS & Under 1 Year onths Days	ocation of Death  A /e  If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Y	4c. County of Dea	ith
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimon		ty, Town or Location		Marsh			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28e	Il Director	10e. Street and Number 5414 Fonge Road		1	Of. Zip Code	1162	100	g. Citizen of What C	. 1
980	72 hours after death with the Maryland Inclurel; or Itams 23a or 28e-f show diest Executes must be natified at	by Funeral		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🌣 No If Yes, Give Year or Dates:		Decedent of His s, specify Cuban Yes 2 X No	panic Origin? (Speci , Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	within ane. than '	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 10th Grade		(Give kind life. DO N	s Usual Occupat of work done du IOT use retired)	iring most of working	16	Sb. Kind of Business Railroad	,
yland	2 should be filed and Mental Hygid Is markad other eumetic event, II	To Be (	17. Father's Name (First, Middle, Last)  John Fisher			-	18. Mother's Name ( Alleyn		,	
	and 2 sho saith and n 27 is ma		19a. Informant's Name/Relationship (Ty Mrs. Nettie Fisher	(wife)	5414 F	orge Rd	nd Number or Rural I			Zip Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		Place of Disposition cometery, cremator udens of		em. 5/20/2		oc. Location - City of Utimore,	
Balt	permit. Pa Departmen Important: any injury once.		21. Signature Funda Service License	99	22. Na	me and Address 5 Belai	of Facility Sch r Rd., Ba	imunek 1 ltimore,	Funeral Ho , MD 212.	
8760,	Physician and for rate of attending physician and for use as the buriar-transit	ical Examiner	23a. Part 1. Enter the disease for complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the death of the cause on each line.	1 I quence of):	a mode of dying.		espiratory arres	it,	Approximate Interval Between Onset and Death
.O. Box 6	ithe death certific by the attending p ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of degular tim	al death 3 Ecto	opic pregnancy er (specify)			23d. Date of de Month	livery Day Year
rds, P	w requires that the s been signed by th should be detache	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the underl	ying cause giver	n in Part I.	23e. Did toba 1 ☐ Yes	A .	o the cause of death?
Vital Record	The law ate has b page 2 sl	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
of	ding Phys h. After this funeral di	atlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	iospital: 1 ☐ Inpatient 2 0 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	DOA Other  28c. Injury a Work?	4   Nursing Home		ce 6 ☐Other (Spe	ocify)
Division	in Direction	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fy)	actory, office	28	f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	Hos Hos ely	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, death occation and/or investig	urred at the time gation, in my opi	e, date and place, an nion, death occurred	d due to the cau at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
)	To the within 2 To the complet	3	29b. Signature and title of certifier	en Cen		. —	53345	4	Date signed (Mon	5
	Sta Registr	3.5	30. Name and address of person/who con DR, Thomas KR, SA. 31. Date filed (Month, Day, Year)  MAY 1 8 20	mpleted cause of death (Item  A 9000   32. Registrar's Signa	TRAUK/I	N Squ	ARE DR.	134171	MORE N	ld 21237

Fisher

ORIGINAL

			1 - For Stete Registrar	State of Ma	-	artment of Health artificate of Death		al Hygien	. U U D	6722
ı	Physici	an	1. Decedent's Name (First, Middle, La	st) Robin	Gregory			te of Death onth Da	•	3. Time of Death 2:30 p. M
	/Medio Examir		4a. Facility Name (If not institution, giv		87	4b. City, Town, or Location	of Death	15	2005 County of Death	
	Lxamii		2768 Virginia	Avenue		Balto			N/A	
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday) 45 Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Da (M	te of Birth onth, Day, Year 15		nplace (State or Foreign untry) MD
	yland Iow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	to	MD NA		Baltimo	re				1 XYes 2 □ No
	or 28	Director	10e. Street and Number		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code		10g. C	itizen of What Co	untry?
	s 23e	ra	2704 Talbott R	oad 12. Was Decedent Ev	ros in II S 12	21216	ining (Specific V		U S A	rican Indian
9	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hydene then "naturel", or Items 23a or 28a-f show item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumetic event, the Madreal Examiner must be notified at	Funeral	11. Marital Status  XXNever Married 2☐ Married	Armed Forces?  1  Yes 2 XNo	·	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical 1 Yes 2 No Specify:		etc.)	Black, White	e, etc.
8	urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				1.01	Specify: B1	
21215-0036	in 72 "nat	Completed	15. Decedent's Ed (Specify only highest gra	ade completed)	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	st of working	16b. I	(ind of Business/l	industry
212	d with giene.	mo	Elementary/Secondary (0-12)  12th grade	College (1-4or 5+		employed		·	Unempl	oved
	al Hygie I other	Be C	17. Father's Name (First, Middle, Last,				er's Name (First			
yla	should be ind Mental I	ပ	John R. Gregor				ria Ou		-	
Maryland	d 2 sho th and 7 is mu treum	1	19a. Informant's Name/Relationship (			ng Address (Street and Numb				ip Code) 21215
	permit. Pages 1 and 2 Department of Health s Importent: If item 27 th any Injury or other tre <u>once</u> .		Toneka G. Greg 20a. Method of Disposition		20b. Place of Dispo		Date		ocation - City or	
Baltimore,	Pages nent of I ant: If ite		1  Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specif			emorial Park	5/20/	O5 Par	dallet	oun - Md
att	permit. Departri Importe any Inju		21. Signature of Funeral Service Licer	nsee ()		2. Name and Address of Facili	ity Marc	h F/H	West	CWIT I'M
8	207 29		Nonnua	U. Thug	M.		ash Ave		alto, Md	
	Pnysician /Medical Examiner		23a. Pa./1. Enter the disease, or com s ock, or heart failure. List only In m-diate Cause (Final disease or condition r so Iting in death)  Sequentially list conditions,	aDue to (or as a	consequence of):	Concer	s cardiac of 165p	natory arrest,		Approximate Interval Between Onset and Death
8760,	ate be executed thysician and the burial-transit	Ical Examiner	a any, wach is to minioriate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
rds, P.	en signed to	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause given in Part	1. 2:		use contribute to	the cause of death?
Records,	0 0	Completed						a. Was an autopsy performed?  ☐ Yes 2 11 11	prior to death?	topsy findings available completion of cause of
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				e of Death (Che	ck only one)		
of\	this al di	၉	1 Yes 2 No	Hospital: 1 Inpatien			ursing Home 5	☐ Residence escribe how inju	ther (Spec	Daughter's
on	ding h. After fune	tlon	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day	Year) Injury	f 28c. Injury at Work?  M 1 Yes 2		ascribe now inju	ary occurred	
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not b	e 200 Place of Injure	y - At home, farm, st (Specify)	reet, factory, office		cation (Street a		ral Route Number,
۵	ospitel or A hours after unerel Direc ly filled in by									
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edical			examination and/or in	h occurred at the time, date an vestigation, in my opinion, dea				
	To the He within 24 To the Fu	Me	29b. Signature and title of certifier	0/11		29c. License number	-	29d. D	ate signed (Month	n. Day, Year)
)	1 /	2	trus (	lan		1)389	72	5/10	2/05	
. /	1-1		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print)			t	
,	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Dr. Fouad Abb	as, 2401	West Be	Lvedere Ave	Balti	more,	Md 21	215
	Sta Regist		MAY	8 2005 Regist	PRINT SE	1				

State of Maryland / Department of Health and Mental Hygiene

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			Registrar				eniiicai	e oi L	Jeath			Reg. N	lo.		1 0 / 1 10 0	
	Dhysisi	20	1. Decedent's Name (First, Middle, Last	)							2. Date of D	D	ay	Year	3. Time of Death	
П	Physici /Medic	al	Steven F. Giberson								May 1		2005		7:12 a M	
	Examin		4a. Fecility Name (If not institution, give		m <i>ber</i> )				Location of	of Death		4		of Death	1	
			1102 E. Viking Co		7 4	de la lace de la lace de		bingo	ION If Under	24 Hrc	0.0			Harf		
1	Funeral		5. Social Security Number 6. Se	x ]M 2□F		(In yrs. last birthda Yrs.	Months	Days	Hours	Min.	8. Date of E (Month, L	Day, Yea	r)	9. Birth	plece (State or Foreign	
H	Director		216-36-1052 Superior	X.	65						July	0, 1	.939	mai	yland	
	land ow		10a. State 10b. County			10c. City, Town or	Location				-,				10d. Inside City Limits	
	Mary	ō	Md. Harfor	d			A	bingo	lon						1 ☐ Yes 24 ☐ No	
	158 288	rec	10e. Street and Number				10f. Zip	Code				10g. C	Citizen of	What Cou	ntry?	
	3a or	<u></u>	1102 E. Viking Co	urt				2	21009				U.S	.A.		
	me 2	Funeral Director	11. Marital Status	12. Was Dec	edent E	ver in U.S. 1	. Was Dece	dent of Hi	spanic Ori	igin? (Spe	ecify Yes or N Rican, etc.)	NO-			can Indian,	
ထ	or ite	F	1 ☐ Never Married 2 ☑ Married	Armed Fe 1 ☐ Yes	2 X N		1 ☐ Yes				rican, etc.)			ck, White, v: wh:		
9	raf. c	by	3 Widowed 4 Divorced	If Yes, Gi Year or D	oates:		I L Tes	ZIZINO	Зреспу.				Specii	y: W11.		
2-0	filed within 72 hours after death with the Maryland Hygione. ther than *natural*, or iteme 23a or 28a-f ehow thet, the Medical Examination and the sindified at	Completed	15. Decedent's Edu (Specify only highest grad		)	(Gi	edent's Usu ve kind of wo	rk done d	uring mos	t of worki	ing	16b.	Kind of B	usiness/In	ndustry	
2	ithin nen nen	du	Elementary/Secondary (0-12)	College (	1-4or 5+	)	DONOTU									
2	led w lygier her ti	Ö	17. Father's Name (First, Middle, Last)	4		fina	ince m	anage		ada Nome	/First Midd			mpan	У	
ğ	be fi	Be	17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Earl Lehman Giberson   Frances Blake										ne)			
<u>₹</u>	I Mer narke	ဥ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town									Canan Ti	- 0-4-)			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinating must be indifficit at 000ce.		Mrs. Shirley Giberson/wife  1102 E. Viking Court, Abingdon, Md. 21009													
<u>မ</u>	1 and Healt Pm 2 ther															
Baltimore,	Pages nent of h ant: If ite		157 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)										gton			
	rtani njury		'4 Donation 5 Other (Specify) Darlington Cemetery 5/13/05 Da													
Ba	Depa Impo any i		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Schimunek Funeral Home of Bel Air 610 W. MacPhail Road, Bel Air, Mo													
P	100		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	licetions that	caused	he death. Do not	610 W	<ul> <li>Mag</li> <li>de of dying</li> </ul>	:Phai g, such as	L Ro	ad, Be or respiratory	A arrest,	r, M	d. 2	Approximate	
			shock, or heart failure. List only of immediate Cause (Final	ne cause on		LREMIA									Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	a. Due to	lorasa	consequence of):										
15	Examiner			2	DIA	consequence of): BETK consequence of): OIABC	K1.	DNE	X	DI	SEA	SE				
	i Cara	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Dus to	(or as a	consequence of).										
	betu:	Examiner	Cause (Disease or injury that initiated events	c.	Æ	) IABC	145	12	152	117	TUS					
oʻ	an ar rial-t		resulting in death) Last	Due to	(or as a	consequence of):										
ox 68760,	n certificate be executed anding physician and use as the buriat-transit	n/Medical		d												
39	ng pt	Wed	IF FEMALE:	000				57:77						20.5000		
	eath ce attendi for use		23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal death	B⊟Ectopic p	regnancy						ate of deliver	ery Day Year	
<u>ا</u>	the all	sici	1 Yes 2 No	4□Preg 9□Unkr		ime of death	☐ Other (s	oecify)				•			,	
P.O. B	w requires that the deat been signed by the atte should be detached for	by Physicia	Part II. Dther significant conditions co	intribution to a	death bu	t not resulting in the	underlying	PALISA DIVE	n in Part I		23e. Dic	tobacc	o use con	tribute to 1	the cause of death?	
ds,	signe signe	i by	Ityper	-			and onlying t	J. 1							bably 4 □Unknown	
Ö	requ	Completed	VASCU				771				24- 146		245	Mara aut		
3ec	e law has l	ldm	110300	J-77 1	12	Emicio						is an lopsy rformed?		prior to co death?	opsy findings available empletion of cause of	
a E	ilcian: The lay certificate has rector, page 2															
ž	ysician: The Is certificate hadirector, page	Be	a examiner?													
o	Phys ral di	- 1º	1 ☐ Yes 2 No  27. Manner of Death	28a. Date	Inpatier of Injury	28b. Time		28c. Injury			28d. Describ				79)	
on	ding h. Afte fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Moi	nth, Day	Year) Injur		Work	:? ∕es 2 🔲	1						
Division of Vital Records,	Attending Physicien: The law requires that the death redeath. sctor: Atter this certificate has been signed by the atter by the funeral director, page 2 should be detached for use	flca	3 Suicide 6 Could not be	28e. Plac	e of Inju	ry - At home, farm,	street, factor	y, office			28f. Location	(Street	and Num	ber or Rur	al Route Number,	
ă	afor safte I Dire	Certification:	4  Homicide	build	ding, etc.	(Specify)					City or I	own, Sta	110)			
	hours hours uners ly fille		29a. Certifier 12 Certifying Phy	sician: To th	e best o	f my knowledge, de	ath occurred	at the tim	e, date ar	nd place,	and due to th	e cause	(s) and m	anner as s	stated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exam	and mar						sun occurr	en at the tim					
	To To E	Σ	29b. Signature and title of certifier  Andrew Me	la . 170	9	01111		c. License		21					Day, Year)	
4	10		Hadawin	we you	CTV.	V VV	-	10	000	40		11/1	4/	11,		
(	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Andrew Nowakowski, M.D., 125 N. Main St., Bel Air, Md. 21014													
	V		Andrew Nowakowsk	L, M.D	• • 1	LJ N. Ma.	TI Dr.	, Del	TATE	, rid	• 7TAT	+				

DHMH 17 Rev 1/2001

State Registrar

			1- For State of Maryland / Department of Health and M Certificate of Death	ental Hygie	_ < U II 5	16726
			Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physici /Medic		Norman John Gromen	May 14,	Day Year 2005	9:45 P M
	Examin		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital  4b. City, Town, or Location of Death Clinton		4c. County of Death Prince G	
E	Funeral Director		5. Social Security Number 5. 77 098472  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye NOV 12,	9. Birth 1917 Mar	place (State or Foreign ntry) yland
	pg ₃ ∷		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Aaryk f sho	or	Maryland Prince George Silver Hill			1 □Yes 2 ₩o
	the the post	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	****
	3a or	i Di	4403 W. Summer Road 20746	U	nited St	ates
	death	nera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or itema 23a or 28e-f show amy injury or other traumatic evant, the Madical Examinat must be notified at once.	by Funerai	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No WWII 1 □ Yes 2 □ No Specify:  3 □ Widowed 4 □ Divorced Year or Dates:	riicari, etc.)	Specify: Wh	ite
2-0	72 ho natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working)	160	. Kind of Business/Ir	ndustry
7	nithin ne.	mple	Elementary/Secondary (0·12) College (1·4or 5+)			
2	iled w tygier than th		12 4 Deputy Dept Head  17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Mai	U.S.D.A.	
Maryland 21215-0036	Mental Harkad of	To Be		ine Spi	,	
	nd 2 sho alth and 27 Is ma r trauma		Norman J. Gromen, Jr (Son)  19b. Mailing Address (Street and Number or Rural 1661 West River Vie			
altimore,	iges 1 ai it of Hea if itam or othe		20a. Method of Disposition  1) Deurial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place) May 20,		. Location - City or T	
턡	it. Pa intmer intent injury		'4 □Donation 5 □Other (Specify) Washington National Ce  21. Signature of Funeral Synxice injensee 22. Name and Address of Facility Lee	100		•
Ba	Depa Impo any ii		22. Name and Address of Facility Election 19 and Address of Facili		•	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r respiratory arrest,		Approximate Interval Between
	Physician :		Immediate Cause (Final disease or condition resulting in death)	discons	9	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	113		ford
В	Lxammer	_	Sequentially list conditions, b.			•
	led isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injurate properties and the conditions of t			
_^	and al-trar	Examin	that initiated events c	· · · · · · · · · · · · · · · · · · ·		
8760,	cate be executed physician and the burial-transit	dicai E	d			
9	tificat ng phy as th	Ψ.				
Вох	death certific e attending p ad for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliv	•
.O.	the d y the iched	Physician/M	in the past 12 months?  1   Yes 2   No 9   Unknown   Unk		Month	Day Year
٦,	es that igned b	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	he cause of death?
ord	v require been sig should b			1 🗋 Yes	2/200 3 □ Pro	bably 4 □Unknown
Vital Records,	e lav	ompleted		24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
ta	(0 -	e C	25. Was case referred to medical 26. Place of Death	(Check only one)	No 1 ☐ Yes	2LI NO
of V	S S	70 B	examiner? Hospital:		e 6 □Other (Speci	fy)
o u			(Month, Day Year) Injury Work?	28d. Describe how i	njury occurred	
Sio	ten leat tor: the	cati	2 Accident investigation M 1 Yes 2 No	206 1	/ 11	10 · · · · · ·
Division	el or Atten s after deatl il Diractor: id in by the	Certification:	4 Homicide  determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S	t and Number or Run tate)	31 Houte Number,
	To the Hospitel or At within 24 hours after or To the Funeral Directompletely filled in by	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the caus ed at the time, date	e(s) and manner as s and place, and due t	itated. o the cause(s)
	To the To the complete	Ź	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month,	Day, Year)
	1	1	D19951		5/16/05	
10	7 /~		30 Name and address of person w/o completed cause of death (Item 23a) (Type, Print)	In 1/2 1.	de l An	N 200111
1	Sta	te.	31. Date filed (Month, Day, Year) 32 (Negistrar's Signature	1 / NATO	May John	10149
	Registr		MAY 1 8 2005 Brown & Special			

Gibson, Willie James

			Please 1	ype or Print in Black I								
			1 State AMEND TITLES	State of Maryland / Dep		Mental Hygien	e nns leads					
			RegistrarAMEND ITEM #	19a PER FH G843 <b>\$</b>	ertifostejor Death	Reg. N	3. Time of Death					
	Physici			SON		Month D	ay Year 37					
	/Medic Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat		c. County of Death					
			SINA: HOSPITHO		BALTMORE		NA					
	Funeral		5. Social Security Number 6. Sex	M 2DE	Months Days Hours Min.	(Month, Day, Yea	9. Birthplace (State or Foreign Country)  3					
	Director		253 · 28 · 5419 Usual Residence of Decedent	82 Yrs.		01.09-192	3 GA					
	ryland	_	10a. State 10b. County	10c. City, Town or I	_		10d. Inside City Limits					
	8a-f s	Director	MD NA	BALTIMO	SE		1 KYes 2 □ No					
	death with the Maryland rms 23a or 28a-f show	Dire	10e. Street and Number	DIALC ALCOUNT	10f. Zip Code	10g. C	Citizen of What Country?					
	ns 23	Funerai	5807 GREENSPR		21209 Was Decedent of Hispanic Origin? (S	necify Yes or No-	USA 14. Race - American Indian.					
0	or Iter		1 ☐ Never Married 2 🖪 Married	1 ☐ Yes 2 🔀 No	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	o Rican, etc.)	Black, White, etc.					
2-003g	ural', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🗗 No Specify:		Specify: BLACK					
ה ה	filed within 72 hours after Hygiene. ither than "natural", or Ite ont, the Medical Exantra	Completed	15. Decedent's Edu (Specify only highest grade	e completed) (Giv	edent's Usual Occupation to kind of work done during most of wo DO NOT use retired)	rking 16b.	Kind of Business/Industry					
7 7	iene.	omp	Elementary/Secondary (0-12)  IH GRADE	College (1-4or 5+)	PUSH OPERATOR	B	AILROAD					
ם ב	m - 0 w	Be C	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide						
ylai	should be nd Menta marked imatic av	To E	GRIFFIN GIBSON		EVA W	PPLE						
a	2 2 2 2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
e,	1 and Health em 27 ther tr		20a. Method of Disposition	IBSON(WIFE) 500 (	GREENSPRING .	AVE., BALT	D. MO 21209 Location - City or Town, State					
	Pages nent of int: If it iry or o		1 ■ Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)		position (Name of ematory or other place)	200.	NDSOR VA					
ащшог	permit, Page Department of Important: If any injury or once.		21. Signature of Funerar Service License		ES GROVE BAPT. 05.2 22. Name and Address of Facility							
Ď	Depa Impo any ii		Wangh (	V <sub>2</sub>	22. Name and Address of Facility AUGHN C. GREENE FL 151 BAUD. NATE PIK	WEKAL SERM E. BAITO: N	CB 10 21229					
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do not er	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between					
	Physician		Immediate Cause (Final disease or condition resulting in death)	SEPSIC			Onset and Death					
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):								
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):								
/	acuted ind transit	amine	cause. Enter Underlying Cause (Ulsease or hijmy that initiated events									
, S	a exectan an an urial-tr	Ĕ	resulting in death) Last	Due to (or as a consequence of):								
00/00	ate be	dicai		l								
Ď K	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical	IF FEMALE:	3c. If yes, outcome of pregnancy								
ממ	atten affor u	cian	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year					
j	that the death ed by the atter detached for	hysi	1	9□ Unknown								
r N	The law requires that the death certificate be exe ate has been signed by the attending physician a page 2 should be detached for use as the burtal-	by P	Part II. Other significant conditions con	•	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?					
ecolus,	equire sen si ould b		TROSTATE CANCE			1 Yes 2	2 No 3 Probably 4 Maunknown					
ט	a law i has b	ompleted	Congestive heres	failure		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
<u> </u>	n: The	O				performed? 1 ☐ Yes 2 🐼 N	death? o 1 ☐ Yes 2 ☒No					
VILA	raician: The law s certificate has b lirector, page 2 s	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	Other	ith (Check only one)						
5	ding Phyaician: h. After this certific funeral director,	-	27. Manner of Death	1 Sinpatient 2 ☐ ER/Outpatient 28a. Date of Injury 28b. Time	of 28c. Injury at	ome 5 Residence 28d. Describe how inju						
5	tending death. tor: Aft the fun	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No							
2	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	nd Number or Rural Route Number,					
2	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Birector: After this certifica completely filled in by the funeral director, to											
	Hosi 24 ho Fune stely fi	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cause( rred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)					
	To the within Fo the comple	Me	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. D	ate signed (Month, Day, Year)					
	> - 0		+ HUn mo		12ES - 000	05	115/05					
	n		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type			1 1					

Registrar
DHMH 17 Rev 1/2001

State

JASON A. YOHO, MA

31. Date filed (Month, Day, Year)

MAY 1 8 2005

2401 W. BELVEDERE AVE., BACTIMENE, 413

			For State Registrar	State of Ma	aryland	d / Depa <i>Cei</i>	irtment of He tificate of E	ealth ai Death	nd Mental H	ygiene () (	)5	16726
П	Discortati		1. Decedent's Name (First, Middle, Last)						2. Date of D	Death Day	Year	3. Time of Death
н	Physici /Medic		Sister Franc	cis	Aile	en	Holly	OSP	May	5 20		1:00p. M
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or		Death	4c. Count		
			Oblate Sisters				Haleth				timo	
	Funeral Director		217-12-0093	7. Ag	e (In yrs. Ia 83	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, I	orth Day, Year) 14 22	9. Birth	place (State or Foreign intry) MD
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limits
	Mary f sho	lor	MD Baltimo	re	F	laleti	norpe					1 ☐ Yes 2 📉 No
	r 28a	rec	10e. Street and Number	<u> </u>	1.	iaice.	10f. Zip Code			10g. Citizen of	What Cou	intry?
	h witi 23a o	alD	701 Gun Road				21	.227		U.	S.A.	
	ems ar ma	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S		Vas Decedent of His Yes, specify Cuban	panic Origi	n? (Specify Yes or N		ce - Ameri	ican Indian,
36	or It	y Fu	1 X Never Married 2 Married	1 ☐ Yes 2X I	No		☐ Yes 2☐XNo	Specify:	,	Specia		
Š	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Modical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		16a D	landa Harral Occurs	M			В	lack
21215-0036	in 72 "nat	Completed	15. Decedent's Edu (Specify only highest grade	completed)		(Give	lent's Usual Occupa kind of work done di DO NOT use retired)	urina most a	of working	16b. Kind of B	usiness/ir	laustry
212	y with jiene. r thar	mo	12th grade	College (1-4or 5	5+)		Teacher			S	choo	1
	2 should be filed within 72 hours after death with the Marylan and Menial Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event, the Modical Examinar mast be notified at	Be C	17. Father's Name (First, Middle, Last)						s Name (First, Midd		me)	
<u>ja</u>	should be ind Mental I marked o	ToE	James Taylor					Mary	Estelle	9		
Maryland	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty	. ,					or Rural Route Num			
	1 and Health Hem 27		Sister Ricardo	Maddox,	OSP			id, H	alethor	-	212	
0	ges 1 If of F If Ite or ot		20a. Method of Disposition  1 Burial 2 Cremation 3 F	emoval from State	200. Pia	metery, cren	sition (Name of natory or other place			20c. Location		
altimore,	it. Pa rtmen rtant: njury		`4 Donation 5 Other (Specify)				on Park		/11/05	Balti	more	e, Md
Ba	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		21. Significant Funeral Service License	2. Trug	Ut	4		l Wes	t ve, Balt		Md	21215
			2 a. P. t1. Enter the disease, or complined, or heart failure. List only or	cations that caused e cause on each li	the death. ne.	. Do not ent	er the mode of dying	, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		In édiate Cause (Final de la se or condition resulting in death)	Dem	en	tia						6 years
	/Medical Examiner		resulting in dealth)	Due to (or as	a conseque	ence of):						J
	3016	e.	Sequentially list conditions, if any, leading to immediate	. Due to (or as	a conseque	ence of):					-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	·							. 4	
ó	exection and and rial-tra	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):						
8760,	ficate be executed physician and sthe burial-transit	edical										
9	ntifica ing ph e as th		IF FEMALE:									
Вох	The law requires that the death certification has been signed by the attending planage 2 should be detached for use as t	Physician/M	23b. Was decedent pregnant	3c. If yes, outcome 1☐Live birth	2 Fetal	death 3	Ectopic pregnancy				ate of deliv	very Day Year
P.O. I	the a	/sic	in the past 12 months? 1 □ Yes 2 XVo 9 □ Unknown	4☐Pregnant at 9☐Unknown	time of dea	ath 5□	Other (specify)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	July 10a
	res that the de signed by the a l be detached f		Part II. Other significant conditions cor	tributing to death b	ut not resul	Iting in the ur	iderlying cause give	n in Part I.	23e. Dio	tobacco use con	tribute to	the cause of death?
ds,	uires sign	d by	Anenia				, ,		1 🗆	Yes 2XNo	3 Pro	bably 4 Unknown
S	w require been si should t	Completed							24a. Wa	s an 24b.	Were aut	opsy findings available
Re	he lav e has	Jub							aut per	opsy formed?	prior to co death?	ompletion of cause of
<u>ra</u>	an: T	Φ	25. Was case referred to medical					26. Place o	1 ☐ Yes of Death (Check only	-	1 🗆 Yes	2□ No
<u> </u>	Physiclan: The this certificate har all director, page	To B	examiner?	ospital: 1 🗌 inpatie	ent 2 E	R/Outpatien	t 3□ DOA Othe	p.	sing Home 5 Re		ner (Speci	in convert
0 0	ng Ph Iter th neral		27. Manner of Death 1 → Atural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry ; y Year) :	28b. Time of Injury	28c. injury Work	at ?	28d. Describe	how injury occur	red	
Division of Vital Records,	tendi eath. or: A the fu	Certification	2 Accident investigation 3 Suicide 6 Could not be					es 2 □ N				
$\leq$	or Att	rtifi	4 Homicide determined	28e. Place of Inj building, et	ury - At hon c. <i>(Specify)</i>	ne, farm, str	eet, factory, office			(Street and Numi own, State)	ser or Run	al Route Number,
_	ours a		29a. Certifier 1 Certifying Physical Certification Physical Certification	ician: To the heat	of my kaa	lledge dozen	continued at the time	a data and	place, and due to th	e Callegée) and m	anner ac	stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certifica completely filled in by the funeral director,	Medical	(Check only one)		f examination							
	To the within To the somple	Me	29b. Signature and title of certifier	5 . 1			29c. License	number		29d. Date signe	d (Month,	Day, Year)
			> marthew	mola	may	MO	D 4	157	57	May	17.	2005
١	1		30. Name and address of person who co		leath (frem		erint)  Ntern	Av	E BAI	+ mj	21	224
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu		~	- 4 -	•	( , –		
	Registr	-	MAY	1 8 2005	Espan	esta de	# Source	0				

			laryland / Dep		Health and M	ental Hygie	ene 2005	10707
		Decedent's Name (First, Middle, Last)		ortinoate or	Death	2. Date of Death	No.L U U J	3. Time of Death
Physici		Dorothy L. Hester				Month	Day Year 6 2005	
/Medic		4a. Facility Name (If not institution, give street and number	.)	4b. City. Town.	or Location of Death	03 /	4c. County of Deatl	
LXAIIIII	iei	Fa 11: 5	lospital	IZ	wsed Al	10	BACT	more
Funeral		5. Social Security Number 6 Sex 7. A	ge (In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	9. Birth	nplace (State or Foreign untry)
Director			74 Yrs.	Months Days	Hours Min.	July 18,	"1930 WV	untry)
and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
Maryli -1 sho	lor	Md. Baltimore	Edgeme					1 ☐ Yes 2X No
h the	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	untry?
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-1 show the Madical Exeminar must be rectified at	alD	2825 Lodge Farm Rd.		212	19		USA	
tams tams	nue	11. Marital Status 12. Was Deceden Armed Forces	Ever in U.S. 13	<ol><li>Was Decedent of I If Yes, specify Cub</li></ol>	Hispanic Origin? (Spe oan, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36 saffe	y F	1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give	No	1 ☐ Yes 2X No	Specify:		Specify: Wh	ite
5-0036 72 hours at natural; or	Completed by Funeral	15 Decedent's Education	16a Dec	cedent's Usual Occu	pation	16	ib. Kind of Business/I	ndustry
215 215 thin 72 an "na	piet	(Specify only highest grade completed)	(Gir	ive kind of work done a. DO NOT use retire	during most of working)	ng	s. rand of Edomood	ridustry
d 212 filed with Hygiene. other ther	E	12 yrs. College (1-4or	He	ousewife			Home	
<b>5</b> 8 1 2 3	To Be C	17. Father's Name (First, Middle, Last) Robert Johnson			18. Mother's Name Hazel			
C 2 2 2 2		19a. Informant's Name/Relationship (Type, Print)  John Berger son		ailing Address (Street 5 Eder Rd.	and Number or Rura Dundalk	Route Number, C		ip Code)
or 1 and 3 and 3 and 37 rother tr		20a. Mathod of Disposition 1 ➡ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dis	sposition (Name of rematory or other pla	ice) Marr		c. Location - City or	Town, State
altimore mit. Pages 1 partment of He portani If iter y injury or oth		'4 □ Donation 5 □ Other (Specify)	Louder	n Park Cer	n. May 200	5', I	Baltimore	
Baltimor permit. Pages : Department of t Important: If tie any injury or of	<	ignature Service Copeed	Ş	Connelly 17110 Solle	euneral Ho ers Point	me Of Dur Rd. 21222	ndalk 2	
Physician /Medical Examiner / Physician and particular francial fr	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequence of): s a consequence of):	FNC CC	ng, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
68 rtificat ng phy as th		15 55 M. S.					Till Silver	
Division of Vital Records, P.O. Box 68's Hospital or Attending Physician: The taw requires that the death certificat 24 hours after death.  9 Funeral Director: After this certificate has been signed by the attending physicily filled in by the tuneral director, page 2 should be detached for use as the teley filled in by the tuneral director, page 2.	by Physician/Med		2 Fetal death 3	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deli Month	very Day Year
ds, P.  uires that the signed by die detail		Part II. Other significant conditions contributing to death	but not resulting in the	e underlying cause gr	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
cord w requir	iete					24a. Was an	24b. Were au	topsy findings available
of Vital Records, Physician: The law requires t this certificate has been signe ral director, page 2 should be	Completed					autopsy performe	d?// death?	topsy findings available ompletion of cause of
ital	ВеС	25. Was case referred to medical			26. Place of Death		10 100	20140
of V nysic nis ce I direc	To E	examiner? 1 Yes 2 No Hospital: 1 Inpat	ient 2 ☐ ER/Outpati	ient 3 DOA	her: 4 Nursing Hon	ne 5 Residenc	ce 6 Other (Spec	rify)
On Of ding Phy h. After thi funeral of		27. Manner of Death 1 Natural 5 Pending (Month, D	ury 28b. Time ay Year) Injury		ry at 2 rk?	28d. Describe how	injury occurred	
SiO eath. or: A	catio	2 Accident investigation			]Yes 2□No			
Division al or Attending to after death. I Director: After	Certification;	determined 286. Flace of II	njury - At home, farm, s tc. <i>(Specify)</i>	street, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Di To the Hospital or within 24 hours aft To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the besigned for the desired form one)	of examination and/or	eath occurred at the ti	me, date and place, a opinion, death occurre	and due to the caused at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and time of certifier	110	29c. Licens		29d	. Date signed (Month	, Day, Year)
		Mo Ho	sp. talist		52024		5/16/05	
8		30. Name and address of person who completed cause of	death (Item 23a) (Typ	e, Print)	<b>n</b>	17 ,		221237
₩ Sta	to.		100 FRAN	ICIIN DO	exte Utiv	e valti	more Vild	21217
Registr	ar	MAY 1 8 2005	K	Last !				

	_ For	State of Maryla	nd / Department of		tal Hygiene	105	6728
	1 - Stata Registrar		Certificate of	Death	Reg. No.		The state of the s
Physician	1. Decedent's Name (First, Middle, Las				ate of Death Jonth Day	Year_	3. Time of Death
/Medical	TARZER	MAE HA	TCHER		louy 14		10:00 AM
Examiner	4a. Facility Name (If not institution, give	el Hospit	4b. City, Town,	or Location of Death	1 40.0 A	NAC AN	indel
Funeral	5. Social Security Number 6. S	9x 7. Age ⟨ <i>ln yrs</i>	. last birthday) If Under 1 Yea  Months Days	r If Under 24 Hrs. 8. E B Hours Min.	Nate of Birth Month Day, Year)	Country	ce (State or Foreign
Director	212-64-7468 1 Usual Residence of Decedent		115.		1 1945	MD MD	
/land	10a. State 10b. County	10c. C	ity, Town or Location			10d.	I. Inside City Limits
Many P-f sh lifted	MD Anne A	rundel	Severn				1 ☐ Yes 2 🙀 No
with the Mar s or 286-f si be notified	10e. Street and Number		10f. Zip Code		10g. Citiz	en of What Country	1?
death with the Maryland ms 23e or 28e-f show critist be multiled at	8159 Village Roa	d 	21.	144	Ţ	JSA	
6 Sufter death v or items 23s	11. Marital Status	12. Was Decedent Ever in the Armed Forces?		Hispanic Origin? (Specify ban, Mexican, Puerto Rica		<ol> <li>Race - American Black, White, etc</li> </ol>	
D36 urs after ur	1 Never Married 2 Married 3 Widowed 4X Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	o Specify:		Specify:	1_
THERE RITES OF THE WITHIN 72 hours after one. Then "neture!, or ite has Wedical Examina has Medical Examina has Medical Examina has medical by Fur	15. Decedent's Ed	lucation	16a. Decedent's Usual Occ	upation	16b. Kin	Black d of Business/Indus	
21215-00 ed within 72 houygiene. "net than "neture it, the Medical Education of the Medication of the Medical Education of the Medication of the Medical Education of the M	(Specify only highest gra	de completed) College (1-4or 5+)	life. DO NOT use retii	e during most of working red)			
d 21. d 21. highwin Hygien with the sent, the	10th	N/A	Homemaker		Но		
be fill the other even.	17. Father's Name (First, Middle, Last)			18. Mother's Name (Fir	st, Middle, Maiden S		
Maryland Maryland d 2 should be fill th and Mental H. I? Is marked out traumatic even		Davis	19b. Mailing Address (Street	Mamie	uta Number City or		strong
Mar Mar d 2 shd th and 7 1s m traum	19a. Informant's Name/Relationship (7) Delores Parker-Ke	• • • • • • • • • • • • • • • • • • • •		eld Dr. Sever		10wn, siaie, zip cc 1144	300)
re, M	20a. Method of Disposition		Place of Disposition (Name of	Date		ation - City or Town	n, State
Pages nent of lint: If its	1XXBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specific		ng Memorial Pa	rk 5/20/20	005 Rand	dallstown	MD
- TEES	21. Signature of Funeral Service Licen	<u> </u>	22. Name and Add	ress of Facility MARCH		HOME-EAST	Г
Bal permi Depar Impo any ir	& lady	Wane	)	North Avenue			1202
	23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the dea	ath. Do not enter the mode of d	ying, such as cardiac or res	piratory arrest,	In	pproximate nterval Between
Physician	Immediate Cause (Final disease or condition	Herr	conty sis			0	Inser and Death
/Medical Examiner	resulting in death)	Due to (or as a conse	guando of):			1	11 - 1/2-
	Sequentially list conditions	b. Due to (or as a conse	al lel a	arcinon	na of	luna 1	riorans
executed executed in and interest	Sequentially list sonditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (01 23 2 001130	quonos or).		0		
60, be executed ician and burial-transit	resulting in death) Last	Due to (or as a conse	quence of):				
:8760, cate be executed physician and the burial-transit		, d					
68 rtiffica ng phras th	IE FEMALE.						
Box Bath cerf eath cerf for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		icy	2:	3d. Date of delivery  Month Da	
Records, P.O. Box 6  The law requires that the death certific the has been signed by the attending to sage 2 should be detached for use as completed by Physician/Me	1 Yes 2 No	4□Pregnant at time of 9□Unknown	death 5 🗆 Other (specify)			WOTE	, 10a
P.O.	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying cause o	given in Part I.	23e. Did tobacco us	se contribute to the	cause of death?
ds, uires ta signe d be of d be of d by	1 appul	porthu	, , , , , , , , , , , , , , , , , , , ,		1 <b>∀</b> Yes 2□	No 3□Probabi	oly 4 🗆 Unknown
A required should be shoul	11.00	motoreto	22		24a. Was an	24b. Were autoos	y findings available
Vital Record sicien: The law requirements to certificate has been sirector, page 2 should be Completed	- CIOCI	116197.0	01		autopsy performed?	prior to compl death?	pletion of cause of
/ital				26. Place of Death (Ch	1 Yes 2 No	1 □ Yes 2	No
of Vita Physician: rithis certificital director,	1 □ Yes 2 1 No	Hospital: Inpatient 2	☐ ER/Outpatient 3 ☐ DOA	ther: 4 Nursing Home		Other (Specify)	
ng Ph		28a. ate of Injury (Month, Day Year)	28b. Time of 28c. In Injury W	ury at 28d.	Describe how injury	occurred	
SiO	2 Accident investigation			☐ Yes 2 ☐ No			
Division of Vital Records, tall or Attending Physician: The law requires to ster death.  To after death.  To Director: After this certificate has been signed in by the funeral director, page 2 should be contributed by Certification: To Be Completed by	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory, offic hify)	9 28f. I	Location (Street and City or Town, State)	Number or Rural R	loute Number,
2 S 2 S 2 C			nowledge, death occurred at the				
o the Hosp lithin 24 hou o the Fune ompletely fill	(Check only		nation and/or investigation, in my				
To the within To the comp	29b. Signature and title of certifier		29c. Lice	nse number	29d. Date	signed (Month, Da	y, Year)
1	Mano X	ille !	1) DC	003274	4 May	1146	2005
170	30. Name and address of person	completed cause of death (Ite		Davis 1	las R.	9:0 115	721011
Current	31. Date filed (Month, Day, Year)	32. Resistrar's Sign		- DRIVE C	RIEN BU	ruc MI	121061
State Registrar	MAY18	2005	K harts				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** CLEOPHUS THOMAS HUNT, SR MAY 14 2005 10:17 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER **BETHESDA** 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 83 Yrs 1921 Virginia 578-14-9090 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other then "naturel", or Items 23s or 28s-1 show try or other traumatic evant, it a Marylaid Exprise mental to notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8609 Dangerfield Road 20735 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give 1945-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates: 1965 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physican Assistant Medical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marvin Hunt Carrie Hartsfield ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter A. Hunt (Son) 9624 Allerton Terr. Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If its eny injury or o once. May 24, 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 2005 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral envige Lice 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of) Examiner physician and s the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 Yes 2**[**] No 1X Yes 2 🗆 No Division of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 

Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 X this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death I Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funerel C 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05 MO 0101056072 (VA) NATIONAL NAVAL MEDICAL CENTER ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name -BETHESDA MD 20889-5600 MARK W. MILLER MC USN LCDR 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registra

DHMH 17 Rev 1/2001

**ORIGINAL** 

			_ For	State of Maryland / Depart	artment of Health and M	•	•	
			1 - State Registrar		rtificate of Death		J. No.	16730
П	Physici	an	Decedent's Name (First, Middle, La	·		2. Date of Death Month	Day Year	3. Time of Death
	/Media		Susanne		odgdon	May 12,		11:10P M
	Examin	er	4a. Facility Name (If not institution, gi		4b. City, Town, or Location of Death		4c. County of Death	
			11243 Mattaponi  5. Social Security Number 6.3	Sex 7. Age (In yrs. last birthday)	Upper Marlboro If Under 1 Year   If Under 24 Hrs.	O Date of Diah	Prince Ge	
L	Funeral Director			1 M 2 F 59 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, ) Dec. 6,	1945 Mich	nplace (State or Foreign Intry) nigan
	land ow		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Mary 1 sh	tor	Maryland Prince	George's Upper	Marlboro			1 Yes 2 No
	r 28a	rec	10e. Street and Number	ocorge 5 opper	10f. Zip Code	100	. Citizen of What Co	untry?
	h with	Funeral Director	11243 Mattaponi	Road	20772		U.	S.A.
	deat	ner	11. Marital Status	<del></del>	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	ican Indian,
21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. d other than "natural", or liems 23a or 28a-1 show event, the Madical Examinar must be notified at	by Fu	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 - Vac 2 - No	1 ☐ Yes 2 🛣 🎖o Specify:	ricari, etc.)	Black, White	hite
ş	2 hou	ted	15. Decedent's E	Education 16a. Dece	dent's Usual Occupation	. 16	6b. Kind of Business/l	ndustry
7	thin 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+) (Give life.	kind of work done during most of work DO NOT use retired)	ing		
7	ad wit	Con	12		ice Manager	F	ree State	Bonds
	0 = 5	Be (	17. Father's Name (First, Middle, Last	it)	18. Mother's Name	e (First, Middle, Ma		
<u>8</u>		To	Ralph R. Pardee	2	Doris A.	Anderso	n	
Maryland	s 1 and 2 should f Health and Mei itam 27 is mark other traumatic		19a. Informant's Name/Relationship		ng Address (Street and Number or Run		•	
_	and ealth m 27				43 Mattaponi Road			
Baltimore,	gas 1 a		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	☐Removal from State 20b. Place of Dispo cemetery, crer	sition (Name of natory or other place)  May	13.	c. Location - City or 1	fown, State
Ē	Pagas Iment of tant: If it jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci		atory 200	5	Clinton, M	aryland
žaii	permit. Pagas Department of I Important: If iti any injury or o		21. Signature of Funeral Service Lice		Name and Address of Facility Lee			
_	00700		MANGE		6633 Old Alexandri			on, MD20735
			shock, or heart failure. List only	inplications that caused the death. Do not ent y one cause on each line.	er the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_aL Breast Cancer				Oliset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
		-	Sequentially list conditions,	b. <u>Wide Spread Meta</u>	astasis			
	per list	ulne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
	be axecuted ician and burial-translt	Examiner	that initiated events resulting in death) Last	c				
) ()	ate be axecuted sysician and he burial-transit	calE	· ·					
28	icate physics the			d				
ROX	requires that the death certilica een signad by the attending ph nould be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliv	/arv
ă	death s atte	Iclai	in the past 12 months?	4☐Pregnant at time of death 5☐	Ectopic pregnancy Other (specify)		Month	Day Year
9	t the	hys	9 Unknown	9□ Unknown				
, v,	s tha	by P	Part II. Other significant conditions	contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ĕ	w requires to been signal should be					1 ☐ Yes	2 <b>X</b> No 3 □ Pro	bably 4 Unknown
Hecords		Completed				24a. Was an	24b. Were aut	opsy findings available
	The law te has b	Eo				autopsy performe	d?   death?	ompletion of cause of
Vitai	(0	a	25. Was case referred to medical		26. Place of Deatl	1 ☐ Yes 2 ☐ n (Check only one)	No 1 □ Yes	20 100
	Physician: this certific ral director,	To B	examiner? 1 □ Yes 2 🏋 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Othor		ce 6 □Other (Spec	ify)
ס ר	tending Physician: leath. tor: After this certific the funeral director.		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of (Month, Day Year) Injury		28d. Describe how		
sion	Attending or death. ector: After by the fune	atic	2 ☐ Accident investigation	on	M 1 Yes 2 No			
<u> </u>		Certification:	3 ☐ Suicide 6 ☐ Could not be determined		eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
	ital o	Cer			′			
	To the Hospital or Ai within 24 hours after of To the Funeral Directorpletely filled in by	edical	29a. Certifier 1 T Certifying Pl (Check only 2 Medical Examone)	thysician: To the best of my knowledge, death miner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2. To the complet	N. C.	29b. Signature and title of certifier	01. 1	29c. License number	290	. Date signed Month	Day, Year)
	50		> Klumm K	Cala Pumbo my	D 23826		5/13/	0.5
6	1		30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print)		-1.01	
0				be, MD 7700 01d Brand		inton. Ma	ryland 20	735
	Sta	-4	31. Date filed (Month, Day, Year)	32. Paristrar's Signature	A seems and	, , , , , , , , , , , , , , , , , , , ,		
	Registr	ar	MAY 1 8	2005 Seems & A				
DIL	MH 17 Day 1/0/	004		•				

Patient Known as: Rachel Harville Baltimore. Maryland 21215-0036

		Please T	<b>ype or Pri</b> State of M											
	1	For State Registrar	Otato or in	ar y larr		rtificat				_	Reg. No.	2000	and the same of th	6731
Physiciar		1. Decedent's Name (First, Middle, Last)  RACHEL P. HA	RVILLE						2	Date of De	ath Day	L Year		me of Death
/Medica Examine			reet and number)	10		4b City,	Town, g	r Location o	f Death	vary	4c.	County of De	ath	.20
		Sinai Hospitu	Lot E	all	Mac	If Under	UM	NWC(	A Hrs I	. Date of Bir	-	N F		tate or Foreign
Funeral Director	1	5. Social Security Number 6. Sex 212 · 34 · 8113	M 2 KF	17	last birthday Yrs.	Months	Days	Hours	Min.	24.24	9, Year) 1928	3	N(	
inyland thow		10a. State 10b. County			y, Town or L									de City Limits Yes 2 ☐ No
with the Mar s or 28a-f sl be notified	2	MD NA		RAL	TIMO	<b>R □</b> 10f. Zip	Code				10g Citi	zen of What C		Tes 2 No
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Evancinational Deposits of To Deformational Associations of the Commissional Associations of the Commissional Associations of the Commissional Associations of the Commissional Associations of the Commissional Associations of the Commissional Office of the Commissional Associations of the Commissional Associations of the Commissional Associations of the Commissional Associations of the Commissional Association of the Commission of the Commission of the Commission of the Commission of the Commis	5	3829 DERBY MAN	IOR DRI	VE			215				rog. Oiti	USA	ountry:	
or Items 23s		11. Marital Status	2. Was Decedent Armed Forces	Ever in U.	.S. 13	Was Dece	dent of I	Hispanic Orig an, Mexican	in? (Spec , Puerto Ri	ify Yes or No ican, etc.)	)-	14. Race - Am Black, Wh		an,
Irs after	2	1 ☐ Never Married 2 ☐ Married 3 【 Widowed 4 ☐ Divorced	1 ☐ Yes 2 【】 If Yes, Give Year or Dates:	No		1 ☐ Yes	2 <b>%</b> No	Specify:				Specify: Bl	ACK	
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within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	CAFT.	DO NOT U	se retire	ORKE	_		RAIT	10. CIT	y sc	21001
2 should be filed with and Mental Hygiene. Is marked other than aumatic event, Ib. M		17. Father's Name (First, Middle, Last)	10/11		GII D	ILNII	10			First, Middle			,	1002
2 should be and Ments Is marked sumatice	2	ROBERT BURGESS						Louis		HEEKS				
INCA od 2 sh lith and 127 is rr traurr	iğ.	19a, Informant's Name/Relationship (Ty)	S (DAUGIT	TER)	3820	•		nand Numbe		BALT		r Town, State, ND 212	21p Code) <b>215</b>	
permit. Pages 1 and 1 permit. Pages 1 and 2 pearlment of Health Important: If item 27 and injury or other tr	8	20a. Method of Disposition		20b. P	Place of Disp				Da			ocation - City o	r Town, St	ate
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permit. Departrimports any inju		21. Signature of Funeral Service Licens			V	AUGHN	nd Addre	SS of Facilit	FUL	IERAL S	ERVIC	£ 21229		
		23a. Part1. Enter the disease, or complishock, or head failure. List only or	cations that cause	d the deat	h. Do not e	nter the mod	de of dyi	ng, such as	cardiac or	respiratory a		<u> </u>	Appro	ximate al Between
Physician /Medical Examiner	alling	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	Catri s a conseq UNIZ	uence of):	new	Ma	Ma	we				Onse C	ylar
an an an an an an an an an an an an an a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as	e of pregna	ancy	□Ectopic p	regnanc	ry				23d. Date of d Month	elivery Day	Year
the at	) old	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant a 9⊡Unknown	at time of d	feath 5	Other (s)	pecify) _					WORKI	Day	i dai
s that t ned by e detac	Dy 7.0	Part II. Other significant conditions cor	tributing to death	but not res	ulting in the	underlying	cause gi	ven in Part I.		23e. Did 1	tobacco ι	use contribute	to the caus	e of death?
requires l	ממו	HNOXIZ Brai	n Jai	m	1					1 🗆	Yes 2	□No 3□I	Probably	4 Unknown
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Physicien: This certificated director, p	ם	25. Was case referred to medical examiner?	lospitat:				. Ct	her		(Check only		- 72		
ng Phys	1001	27. Manner of Death  1 Natural 5 Pending	1 Nnpat 28a. Date of Inj (Month, D	ury	28b. Time Injury	of	28c. Inju	4 140	28	e 5 ∐ Resi 8d. Describe		6 □Other (Sp ry occurred	ecify)	
To the Hospitel or Attending within 24 hours after death.  To the Funeral Director, After completely filled in by the fune	Certification	2 Accident 3 Suicide 4 Homicide	28e. Place of tr building, e	njury - At h tc. <i>(Specil</i>	ome, farm, s fy)	treet, factor				Bf. Location ( City or To		nd Number or i	Rural Route	Number,
Hospite 1 24 hours 10 Funerel Fetely filled	Medical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the bes ner: On the basis and manners	of examina	owledge, dea	ath occurred investigation	at the t	ime, date an opinion, dea	d place, ar th occurre	nd due to the d at the time,	cause(s)	) and manner d place, and d	as stated. ue to the ca	use(s)
To th withir To th comp	M	29b. Signature and title of certifier	11.0	DA		29	c. Licen	se number	_		29d. Da	te signed (Mo	nth, Day, Y	ear)
		- Ween Just	ran	KU.	- 00 : =	1	F	2-00	U		149	414	,20	US .
9		30. Name and address of person who co	impleted cause of	Geath (Iter	m 23a) (Typi	DSO17	l!	of f	300+	imar	e	$\cup$		
State Registra	_	31. Date filed (Month, 1) Year 8 20	05 32 egist	trar's Signa	ature	Seast?	5							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 15 1200 PM 6 Hatermalz 2005 rances /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University Mary land Baltimore
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F Months Days Hours NEW YORK 88 Yrs. Director 058-16-5819 3/19/1917 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-1 show Examinact rust by notified at 1 ☐ Yes 2 ☐XNo Director NY TOMPKINS DRYDEN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 64 LAKE ROAD items 23e 13053 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: Specify: WHITE þ 3 XWidowed 4 ☐ Divorced "neturel" Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) treumatic event, the Medical 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. HOMEMAKER OWN HOME and Mental Hygie is marked other t 12 GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ROSS GALPIN MAUDE HENDERSON GALPIN ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ROGER ZILLIOX/SON 1691 PARKER STREET CORTLAND, NY 13045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it eny injury or o ō 1 

Burial 2 □ Cremation 3 □ Removal from State MAPLE GROVE CEMETERY 5/23/2005 CANDOR, NY 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signatur - of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON. MD Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dreumonia Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 Yes 2 No Vital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient P 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA this o 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: / 2 Accident 6 ☐ Could not be 3 🗍 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the within 2 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number MD 17672 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 Greene St Baltimore South 22 Fontanilla vonne 31. Date filed (Month, Day, Year) distrar's Signature State MAY 1 8 2005 Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Day Month **Physician** ensor May 200( arence /Medical ation of Death 4a Facility Name (If not institution, give street end number) Examiner more Baltimore romwel If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min Months Hours 1 □ M 2 □ F Yrs. Director 217-20-6067 Jul 14, 1927 Md Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 TWes 2 □ No Baltimore Director N/A Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1500 North Decker Avenue 21213 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: \$ Black 3 ☐ Widowed 4 ☐ Privorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Kopper s Company is marked other than Steel Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mabel Henson Walter Henson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Heelth end I important: If Item 27 is me 19a. Informant's Name/Reletionship (Type, Print) 2810 Ulman Avenue Baltimore, Md. 21215 Walter Henson Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Owings Mills, Md. 05/23/05 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Liceo Estep Brothers Funeral Service PA 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown <u>ک</u> cular Disease 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? pege 2 ino 1 Yes 20 40 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Pending

or Attending Physician: The lew requires that the death certificate be executed ettending physician end for use es the buriel-trensit P.O. Box 68760. signed by the e Division of Vital Records. hes Certification: To this Director: After the efter death. within 24 hours efter To the Funeral Direc completely filled in by Medicai

Peges 1 and 2 should be filed within 72 hours efter deeth with the Meryland

Baltimore, Maryland 21215-0020

6 Could not be determined

1 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 🗆 No

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

296. Signature and title of certifig

investigation

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a), (Type, Print) 60 9000 110

31. Date file (Month, Day, Year)

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only

32. Registrar's Signature

**DHMH 16 Rev 6/95** 

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) HOWARD **Physician** HIPSLE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 153M 2□ F Yrs. 89 1915 Director 215-09-8185 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c, City, Town or Location 10d Inside City Limits 10a. State or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Baltimore Catonsville Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. "neturel", or items 23e 508 Rest Avenue 21228 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give WW Year or Dates: WW 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Salesman 12 Insurance 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Mental Is marked Howard H. Hipsley Dora Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 I 508 Rest Avenue Catonsville, MD 21228 Grace V. Hipsley (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 5-21-2005 Laurel, Maryland \* 4 □ Donation 5 □ Other (Specify) Balto/Wash Crematory | 22. Name and Address of Facility 21. Signature of Huneral Service Licensee Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a prosequence of Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's 2X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To te of Injury (Month, Day Year) 28c. Injury at Work? Manne of Death 28d. Describe how injury occurred 28b. Time of After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide e Funerel I 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) anoka Ohesinin Down 31. Date filed (Month, Day, Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 9:40 Ruth Elizabeth Johnson 2005 mar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 5701 Kenwood Avenue Baltimore County Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 ☐ M 2 ☐ F Director 219 10 3039 80 April 9 1925 Dundalk, Maryland Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28e-1 show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "naturel", or Items 23a or 28e-1 show other treumatic event, the Medical Examinar must be notified at Maryland Baltimore Baltimore County 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5701 Kenwood Avenue 21206 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer Baltimore Federal Credit Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James A Cox Elizabeth Grieb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Ruth Marshall (daughter) 302 Fiddler's Point Drive St Augustine, Florida 32080 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō \* 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. May 19 2005 Baltimore, Maryland injury 22. Name and Address of Facility 21. Signature of Funeral Service Licensee any ii Lassahn Funeral Home Inc. 23a. Part1. Enter the disease, or complications that cabeed the death. Do not enter the mode of dying, such as cardiac or respiratory ariest. Approximate Interval Between Onset and Death Immediate Cause (Final olon **Physician** week 15 mon disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 3 No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No P 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Thomicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 024356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weinber Cone Uno WINCLVATERFIELD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar WAY 1 8 2005

UNK )5**-**03187 gll Alphonso

hons	o Jack	.evi	For State Registrar	State of Maryland		artment of H		nd Mental		2000	16726
710113			Decedent's Name (First, Middle, Landson L	ast)	00/	tinoato or i	Jean	2. Date of	Reg. If Death	No. O O C	3. Time of Death
	Physic /Medi		ALPHONSO WENDEL	I. JACKSON				Month		oay Yea )∩5	ar M
	Exami		4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of		-	4c. County of D	5:57 A ™ eath
			Prince George's H	Hospital Center		Cheverly	7		F	Prince (	George's
No.	Funeral		-	Sex 7. Age (In yrs. la XIXM 2□ F	**	If Under 1 Year Months Days	If Under 24 Hours		f Birth , Day, Yea	9.1	Birthplace (Stete or Foreign Country)
	Director	ļ	UNKNOWN Usual Residence of Decedent	7	1 Yrs.			MAY	-		ASHINGTON, DC
	/land		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Man a-f sh	tor	MARYLAND PRINCE	GEORGES LARG	<del>7</del> 0						XX Yes 2 □ No
	after death with the Marylan or Itama 23a or 28a-f show	Director	10e. Street and Number	22111		10f. Zip Code			10g. (	Citizen of What	Country?
	23a c		81 JOYCETON TERRA	CE		20785			UN	TTED ST	'ATES
	tama tama	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origi n, Mexican,	n? (Specify Yes of Puerto Rican, etc			mencan Indian,
36	rs afte	by F	XX Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes XXX No If Yes, Give Year or Dates;		I □ Yes X2X No	Specify:		,	Specify: B	
O <sub>P</sub>	72 hours after death with the Maryland "natural", or Itama 23a or 28a-f show falloul Exertified in the motified at	edt	15. Decedent's E		16a Decec	ient's Usual Occupa	ation		166	Kind of Busine	
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			23a. Part1. the disease, or conshock, or heart failure. List only	plications that caused the death one cause on each line.			g, such as ca	ardiac or respirato	ry arrest,		Approximate Interval Between
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Вох	eath certif attending for use a	clan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy				23d. Date of o Month	delivery Day Year
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Di√	after Dirac Jirac	Certification:	4 Homicide determined	building, etc. (Specify)		10		City or	Town, Sta	te) 3910	Rural Route Number, 62nd AV2
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	To the Hoapital or Attendii within 24 hours after death. To tha Funeral Diractor: Al completely filled in by the fu	Medical	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	on and/or inv	estigation, in my op	inion, death	occurred at the til	ne, date ar	nd place, and d	ue to the cause(s)
	To T	2	29b. Signature and title of certifier			29c. License		-	29d. D	ate signed (Mo	nth, Day, Year)
1	1	/		· mis					May	8, 200	5
0	10		30. Name and address of person who	completed cause of death (Item	23а) (Туре, Р	111 Penn	Stree	t Balti	_		and 21201
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State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2005 Year **Physician** May 13, Kriss 5:46 P M Joan MAry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 2249 Searles Road Dundalk If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F November 21,1936 68 219-32-6871 MD. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MD. Baltimore Dundalk Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2249 Searles Road 21222 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours atternent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give TYear or Dates: Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. 12 years Housewife Own Home of Health and Mental Hygic fitem 27 is marked other r other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဝ Joseph Bialecki Mary Marzec 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2249 Searles Road, Dundalk, MD. 21222 Edward Kriss Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) May 17, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of tImportant: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cemetery 2005 Baltimore, MD. 21. Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between S U EUS Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician as the IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year ō 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 Probably 4 Unknown 1 TYes peeu 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 5 Residence 6 Other (Specify) 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D41406 on who completed cause of death (Item 23a) Type, Print) ANCER CONTER, 6569NCHARLES THAUDHRY CIBMIC CANCER CONTER, 6569NCHARLES 2. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 1 8 2005 State Registrar

			Please Type or Print In Black		-	•	
			201	epartment of Health and Men <i>Certificate of Death</i>	tal Hygien Reg. N	2005	6738
	Physici	an	1. Decedent's Name (First, Middle, Last) Charles A Kreider		Date of Death Month 15 2	Pay Year	3. Time of Death 12:45 A M
	/Media	čal.	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		tc. County of Death	12.4J A M
	Examir	ier	Gilchrist Center	Towson	Ι.	Baltimore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Iday) If Under 1 Year   If Under 24 Hrs.   8, p	Date of Birth Month, Day, Yea		ace (State or Foreign
	Director		220 20 1000 X /8		ovember 2		
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10	d. Inside City Limits
	the Marylar 28e-f show	ctor	Maryland Baltimore City Baltimo	æ			1 ☐ Yes 2 ☐ No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Count	ry?
	s 23e	ral	7 Morningstar Court	21206		USA	n ladian
	ter de	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 XMarried 12XX 9 2 No	<ol> <li>Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical</li> </ol>	n, etc.)	14. Race - America Black, White, e	tc.
036	ral', or	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WW II	1 ☐ Yes 2 ☒ No Specify:		Specify: Whi	te
5-0	72 ho	etec	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working	16b.	Kind of Business/Indu	ustry
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-1 show ha Medical Evaminar must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Fin	life. DO NOT use retired)  Bince Manager	C		3° L
	filed Hygid othar ant,	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fir		mmercial Cre	QLL.
/lar	2 should be filed within and Mental Hygiene. Is marked othar than aumatic evant, the Me	To B	Asher H Kreider	Helen McCormi	ck		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It was 12 is marked othar than "natural", or Items 23e or 28e-1 show itam 27 is marked othar than "natural", or Items 22e or 28e-1 show ither traumatic event, the Medical Evanturer must be notified at			Mailing Address (Street and Number or Rural Ro			Code)
	1 and 3 Health tam 27			Morning star Court Baltimo Disposition (Name of Date	re, Mryl	and 21206 Location - City or Tow	vn. State
nor	Pages nent of I int: If its iry or o		cemeter	of Faith May 18 2005		timore,Maryla	
Baltimore,	- F # F		21. Signature of Funeral Service Licensee	22. Name and Address of Facility		) )	
8	Depar Impor any ir		23a. Part 1. Enter the disease, or complications that caused the death. Do n	Lassahn Funeral Home Inc	e. Marvla	nd 21226	
			shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
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68760,	eath certificate be ex attending physician for use as the burial	Completed by Physician/Medical	d				
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Ω.	hat the	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e. Did tobacco	o use contribute to the	cause of death?
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COL	sw requir s been si should	olete	, , , ,	,	24a. Was an	24b. Were autop	sy findings available
Re	The la	mo			autopsy performed? 1 ☐ Yes 2 ☐	death?	pletion of cause of 2□ No
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of	Physician: this certific ral director,	-T	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ EP/Out  27. Manner of Death 28a. Date of Injury 28b. T	patient 3 DOA Other: 4 Nursing Home	5 Residence	6 Other (Specify)	H <b>é</b> spice
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Division	I or Attandi after death. Diractor: A	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office 28f. I	Location (Street City or Town, Sta	and Number or Rural	Route Number,
Ö	itel or irs after ral Dire						
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 15 Certifying Physician: To the best of my knowledge (Check only one) 2 ☐ Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and of or investigation, in my opinion, death occurred at	due to the cause t the time, date a	(s) and manner as sta and place, and due to	ited. the cause(s)
	To tha within 2 To tha comple	Med	29b. Signature and title of certifier	29c. License number	29d. C	Date signed (Month, D	Pey, Year)
	(1		ALLW COL	D0057926	W	ray 15	2005
ì	OKI		30. Name and address of person who completed cause of death (Item 23a) (		1 N. Cha	arles Stre	et
7	V		Helen M. Gordon W.  31. Date filed (Month, Day, Year)  32. Register's Signature	D Tow	son, MD	21204	
*;	Sta Registi		31. Date filed (Month, Day, Year)  32. Register's Signature  MAY 1 8 2005	K Appelled			
	, ,	204	MIKI TO FACE TO SEE	€′			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) May 16 2005 Thelma 2:45 Рм Julia Knobel 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Oak Crest Parkville Baltimore If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Min. Hours 1 □ M 2 □ F October 20 1912 Virginia 216 30 0700 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5903 Trumps Mill Road 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ₩No 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Russell T Baker Realtor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles H Williams Daisy Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9500 Amberly Lane Perry Hall, MD. 21128 Margaret K Rowe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State May 19 2005 Cardens of Faith Baltimore, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery 23b. Was decedent pregnant Year

**Physician** /Medical **Examiner** 

burial-transit

the

attending physician

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certificate has

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funaral Director: After this certifica

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examine

Physician/Medicai

by

Completed

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Certification:

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injury or

**Physician** 

/Medical

Examiner

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Funeral

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itam 27 is marked other than "netural", or Itams 23a or 28a-f show other traumatic avant, the Medical Examinet must be neithed at

Department of Health and Mental Hygiene. Important: If itam 27 is marked other than

of Health and Mental Hygiene.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

in the past 12 months?

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown ngs available of cause of

autops		prior to death?	completion
1 ☐ Yes 2		1 🗆 Yes	2□ No
heck only on	9)		

25. Was case relerred to medical examiner? 26. Place of Death (C Hospital: 1 ☐ Inpatient Other: 1 Yes 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗌 Accident 3 🗌 Suicide

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

W

32. Registar's Signature

28l. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number

e and address of person who completed cause of Seath (Item 23a) (Type, Print)

MAY 1 8 2005

MEMENTA

31. Date filed (Month, Day, Year)

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State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MAY Day 13 **Physician** 2005 7:40P ANNA LEE KIRKWOOD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 22, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F Months ¶920 Mary Tand 215-14-9340 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heath and Mantal Hygiene.
sent of Heath and Mantal Hygiene.
sent if flear 27 is marked other than "natural", or flems 23e or 28e-f show any or other treumatic event, its Madical Extra recounts to natified. 1 ☐ Yes 2 ☑ No Director Towson MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21286 USA 1122 Concordia Drive Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No 3altimore, Maryland 21215-0036 Specify: þ Specify: 3 ₩ Widowed 4 Divorced white Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Estelle Wise Milton C. Klutch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann K. Robinson / daughter 4704 Rocky Mills Drive; Frederick, MD 21703 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Importent: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Species no Combinent Dulaney Valley Mem Gardens 5/19/05 Timonium, MD 21. Signature of Funeral Project Licensee 22. Name and Address of Facility 1050 York Road etu Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (dinted type Enysician Cardiongo years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ŏ Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo To the Hospitel or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Homicide within 24 hours a To the Funerel I 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 100041619 crner 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 14, 2005 11:45 am Edward S. Lange 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dundalk Baltimore Heritage Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 212–20–7983 8. Date of Birth (Month, Pay, 1923) April 18, 1923 Birthplace (State or Foreign Country)

VA. 7. Age (In yrs. last birthday) Days Hours Months 1**X** 1 M 2 □ F 82 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Dundalk Baltimore 10g, Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21222 1802 August Avenue 12. Was Decedent Ever in U.S. Amped Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) National Cash Register Repair Tech 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna Bowles Cottrell Lange Edward Charles Lange 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1802 August Avenue, Dundalk, Md. 21222 19a. Informant's Name/Relationship (Type, Print) wife Ethelyn Lange Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State MAy 16,2005 Baltimore City, MD. Bayview Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Connelly Funeral Home Of DUndalk, P. A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease or complications that caused the death. Don't enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify)

Physician /Medical **Examiner** 

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Baltimore, Maryland 21215-0036

Examiner burial-Physician/Medical the ö ð Completed page 2 Be 2 Certification;

The law requires that the death certificate be executed

Box 68760,

P.O.

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Division of Vital

To the Hospitel or Attending Physicien:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 25. Was case referred to medical

9 Unknown

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient 2 ER/Outpatient 3 DOA

24a. Was an autopsy performed 1 Yes 25 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 TYes

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7.	Manner of 1 Dratura 2 Accide	Į.	5 ☐ Pending investigation	n	2

28a. Date of Injury (Month, Day Year) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)	2 ☐ Medical Examiner:				he cause(s) and manner as stated. he, date and place, and due to the cause(s)
29b. Signature and	d title of certifier	. /	29c. License nu	ımber	29d. Date signed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

3 Suicide

4 Homicide

31. Date filed (Month, Day

determined

Ragistrar's Signature

ath (Item 23at Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** М 1:00P MAY 15, 2005 DOROTHY LYLES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES LAUREL REGIONAL HOSPITAL LAUREL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1□M XXF Yrs. MAY 22, SOUTH CAROLINA 1954 Director 241\_96\_8402 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County ir than "natural", or Items 23e or 28e-f show the Medical Exercit or must be notified at XX Yes 2 No Directo MARYLAND PRINCE GEORGES LANDOVER 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number UNITED STATES 20785 7743 MUNCY ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married XXMarried Baltimore, Maryland 21215-0036 1 Yes XX No Specify Specify: BLACK Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL ASSISTANT 12TH . Pages 1 and 2 should be filed w tment of Health and Mental Hygier tent: if Item 27 Is marked other ti jury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHNNIE BRUNSON ANNIE ADAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LANDOVER, MD 20785 DERRELL M. LYLES, SR. HUSBAND 7743 MUNCY RD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XIX Burial 2 Cremation 3 Removal from State Department of Importent: if any injury or once. MARYLAND NAIONAL CEM. 05/21/2005 4 ☐ Donation 5 ☐ Other (Specify) LAUREL, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Eaching MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician METASTATIC BREAST CANCER /Medical Due to (or as a consequence of) **Examiner** PULMONARY EMBOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit requires that the death certificate be executed PNEUMONIA Due to (or as a consequence of) Box 68760, Physician/Medical RADIATION PNEUMORITIS IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes No ŏ 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unkno 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1 ☐ Yes XX No 3 Probably 4 Unknown DIABETES Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 🗆 No 1 Yes 1 ☐ Yes 🗶 🗓 No Hospitel or Attending Physicien: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital:XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes XX No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: XX Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 0 acr cause of death (Item 23a) (Type, Print) 30. Name and address of pers 1635 32. Registrar's Sig 31. Date filed Month, Day, Year, State Registrar

			1- State of Maryland / State of Maryland /		artment of H		nd Ment	al Hygie	7 U I I	5 16743
			Decedent's Name (First, Middle, Last)	1		-		ate of Death		3. Time of Death
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	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		Death		4c. County of	Death
			Villa St. Michael Nursing & Rehab.  5. Social Security Number 6. Sex 7. Age (In yrs. last		Baltir If Under 1 Year		4 Hrs   e Do	ate of Birth	N/A	. Birthology (Out)
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Division of Vital Records,	een si	ted				<del></del>		1 🗌 Yes	2 12 150 3	Probably 4 Unknown
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<u>≥</u>	r Atterde	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, str	reet, factory, office		28f. Lc	ocation (Stree	at and Number	or Rural Route Number,
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	141		30. Name and address of person who completed cause of death (Item 23	a) (Type,	Print) // /	15	02.2	11	7 - 11	1 2:= -
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			1 - For State Registrar State of Maryland / Department of Certificate of			ene 2005	16744
	Physici /Medic		Decedent's Name (First, Middle, Last)     MAZIE LESLIE		2. Date of Death Month MAY 1	Day 2005	3. Time of Death 8:55 A. M
	Examir		HOSPICE OF BALTIMORE-GILCHRIST CENTER T	or Location of Death			TIMORE
	Funeral Director		5. Social Security Number 219-58-7498  6. Sex 1 M XX F 83 Yrs.   If Under 1 Yea Months Day:	ar If Under 24 Hrs. rs Hours Min.	8. Date of Birth (Month, Day, Y 12-30-19	9. Bi	rthplace (State or Foreign Ountry) MARYLAND
	Maryland f show	or	10a. State 10b. County 10c. City, Town or Location	WSON			10d. Inside City Limits 1 ☐ Yes 💢 No
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19	21215-0036 d within 72 hours af giene. er than "neturat", or tre Madical Exam	Completed	15. Decedent's Education 16a. Decedent's Usual Occ	ne during most of workir ired)	ng	b. Kind of Busines:	s/Industry CARE
115/05	Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is merked other than "any injury or other treumetic event, ILEMM DDG.	To Be C	17. Father's Name (First, Middle, Last)  JOSEPH MULLINIX	18. Mother's Name	(First, Middle, Ma	,	NIX
10	Mary		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  KATHERINE H.LESLIE (DAUGHTER)  19b. Mailing Address ( <i>Street</i> )  14217 QUAIL (				
5	Baltimore, permit. Pages 1 a Department of Hes Importent: If item any injury or othe page.		20a. Method of Disposition  XX Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetary, crematory or other p. DULANEY VALLEY M.			c. Location - City o	
Mazie	Balti permit. Departn Importe any inju		21. Signature of Funeral Septide Licensee  22. Name and Add RUCK TOWS(	on FUNERAL	HOME, INC	1050 YO . TOWSON,	ORK ROAD MD.21204
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	/Medical Examiner	L	Due to (or as a consequence of):  Sequentially list conditions,  b. Due to (or as a consequence of):	+			weeks
1/150	8760, cate be executed only sician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):				weeks
	Records, P.O. Box 68760 The law requires that the death certificate be eath has been signed by the attending physician tage 2 should be detached for use as the buritable.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[ Yes 2 \] \[ Yes 2 \] \[ Yes \]			23d. Date of de Month	elivery Day Year
	ds, Purities that a signed but details	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of Early Stage Reval Disease.	given in Part I.	23e. Did tobac	A	to the cause of death?
		Completed			24a. Was an autopsy performe	prior to	
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	Division of Vital Reventing the Hospitel or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 11		28d. Describe how	injury occurred	Hospice
	Divis	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	:е 2	28f. Location (Stree City or Town, S		Bural Route Number,
	he Hospi in 24 houl he Funer pletely fill	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	time, date and place, a y opinion, death occurre	ed at the time, date	and place, and du	e to the cause(s)
	To t withi To th	Σ		onse number 00 519 24c		Date signed (Mor	2005
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Helen M. Gord M. W.D		6601 N. Towson,	Charles MD 21204	Street
	Sta Regista		31. Date filed (Month, DayMAN 1 8 2005 Registar's Signature	5			

			For State Registrar	State of M	arylan	•	artmen rtificat			and M	•	giene		10716
	Physici	an	1. Decedent's Name (First, Middle,	•			1 .				2. Date of Dea		Year	3. Time of Death
	/Medic			Fred	Albe	rt 1	Lovel				May	14, 2005		5:30 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution,	•	Caro	C+x	4b. City,	Town, or Dunc	Location of	of Death		4c. County o		imore
			Genesis Herita			ast birthday)	If Under		If Under:	24 Hrs.	8. Date of Birt			
	Funeral Director		705-12-5248	1⊠M 2□F	85	Yrs.	Months	Days	Hours	Min.	(Month, Da)	y, Year)	Cou Oh:	place (State or Foreign ntry)
	D		Usual Residence of Decedent								buly 1	0/1313		
	e Marylar le-f ehow	ctor	Maryland 10b. County	Baltimore	10c. City	, Town or Lo	ocation			D.	undalk			10d. Inside City Limits 1 ☐ Yes 2 🛣No
	or 28	Dire	10e. Street and Number 1954 Dineen Di	r-i 170			10f. Zip	Code	2	1222		10g. Citizen of W	hat Cou	ntry?
	e 23a	iral			E in III	0 10	144 D -					United		
36	permif. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Iteme 23a or 28e-f ehow any fujury or other treumetic event, Ite Medical Exeminational Legisla and page.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Marrie  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	No		was Deced If Yes, spec 1☐ Yes		Specify:		acify Yes or No Rican, etc.)	Specify:	, White,	can Indian, etc. White
21215-0036	2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usua kind of wo	al Occupa	ition	t of worki	ing	16b. Kind of Bus	siness/In	
2	thin 7 e.	Completed	(Specify only highest Elementary/Secondary (0-12) 10 Years	College (1-4or	5+)	life.	DO NOT us	se retired,	unng mosi )	I OF WORK	ng			
	ygien ygien her th	Con				Planr	ning I	Engir			(FE) . A 4	Railro		
and	nfal H ed otf	Be	17. Father's Name (First, Middle, L Fred Lovell	ast)							Dykes	Maiden Sumame	•)	
<u>=</u>	hould d Mer mark matic	으	19a. Informant's Name/Relationsh	in (Type Print)		19b Mailie	na Address	(Street a				ar, City or Town, S	State Zir	2 Code)
Maryland	th an the street of the street		Florine W. Lov				-					Maryland		1222
	s 1 ar f Hea item (		20a. Method of Disposition		20b. P	lace of Dispo	osition (Nar.	ne of	2)	C	Date	20c. Location - C	City or T	own, State
Ë	Page nent o int: If iry or		1 □ Burial 2 ☑ Cremation  1 □ Donation 5 □ Other (Sp							5/1	9/2005	Towson	, Ma	aryland
Baltimore,	permif. Departrimporte any Inju		21. Signature of uneral Service L	icensee	2	10						Dundalk Maryland		
			23a. Part1. Enter the pisease, or o shock, or heart allure. List of	complications that caused	the death	n. Do not ent	ter the mod	e of dying	g, such as	cardiac c	or respiratory ar	rest,		Approximate
	Physician		Immediate Cause Final disease or condition	a. CHRON  Due to (or as	110	085	TRY	171	UE	Pu	CMBND	ARY DIS	FA	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):			<i></i>	88	0.5	1-1-	-	
	Examines	<u>.</u>	Sequentially list conditions,	Due to (or as	5/11	IE A	(EP)	27	FA)	14	OKE		_	_
LV	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	DEVICE	a consequ	/A)								
4	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):							-	
8760,	e be e /siciar e buri	cail		d. DE-H	10	RAT	1101	4						
9	tificat ng phy as th				/-									-
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			⊒Ectopic pr	egnancy				23d. Date		•
0		sici	1 Yes 2 No	4□Pregnant a 9□ Unknown	t time of de		Other (sp					Mon	tt1	Day Year
Ρ.	that the de ted by the a detached f		Part II. Other significant condition	s contributing to death h	out not resi	ulting in the u	enderlying c	alisa dive	n in Part I		23e. Did to	phacco use contri	bute to t	he cause of death?
Records,	law requires that the as been signed by th 2 should be detache	ed by								· 		_	3 ☐ Prot	
ecc	law re as be 2 sh	Completed									24a. Was	an 24b. W	ere auto	ppsy findings available impletion of cause of
= =	The page	Соп										rmed? de	eath?	2 <b>1</b> 0 No
Vital	icien	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death	(Check only o	ne)		
of	Physicien: r this certific ral director,	T.	1 Yes 2 No	1 ☐ Inpatie		ER/Outpatier 28b. Time o		JA	4 Mu	-		dence 6 Other	` '	(y)
	ding h. After funer	tlon	1 Catural 5 Pending 2 Accident Investiga		y Year)	Injury	M	8c. Injury Work 1 ☐ \	:?`` ∕es 2		cod. Dosonoo i	iow injury occurre		
Division	Attending r death. sctor: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of Inj	jury - At ho	ρṃe, farm, sti	reet, factory					Street and Numbe	r or Rura	al Route Number,
ă	el or A s after of Direct	Certification;	4 Homicide	building, et	tc. (Specit)	/)					City or Tox	vn, State)		
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best xeminer: On the basis of and manner st	t examina	wledge, deat tion and/or in	h occurred vestigation	at the tim , in my op	e, date an inion, dea	d place, a	and due to the e	cause(s) and man date and place, ar	ner as s	stated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2 ( /	-		290	. License	number	11	2	29d. Date signed	(Month,	Day, Year)
•			Sand	2x 11/11	elle	MI	>	() 2	27	18	8	5/16/	95	
	1.11		30 Marme and address of person w	the completed cause of c	death (Item	23a) (Type,	Print)	+ 5	0/2	_	Dien	BALL	KI	02/222
	0 / / Sta	te	31. Date filed (Month, Day, Year)	32. Registr	rar's Signa	ture	1100	-	M		Jul.	Melle !	1)	1-14-
	Registr		MAY 18	2005		KA		î						

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ORIGINAL

			1 - For State Registrar	State of I	Marylar	•	artmer			and M	-	giene Reg. No.	200	5 16	71.0
	Physici /Medio Examin	al	Decedent's Name (First, Middle, L     Aa. Facility Name (If not institution, g.	Paul	Rich	nard			nd, Si		2, Date of De Month May	Day 15,		8:57	of Death C
	Funeral	ler	7943 Wise Aven	ue		last birthday)		Dunc r 1 Year			8. Date of Birl	th	Balti	more Co	
	Director		213-32-6419 Usual Residence of Decedent	1⊠M 2□F	67	Yrs.	Months	Days	Hours	Min.	(Month, Da Feb. 1			Sirthplace (State Country) ryland	
	Ba-f show	Director	Maryland 10b. County	Baltimor		ty, Town or Lo			Dui	ndal	ζ				City Limits
	eath with the 1s 23s or 2 must be n	Funeral Dire	10e. Street and Number 7943 Wise Ave 11. Marital Status	nue	nt Ever in U	S 13.1		dent of Hi	21222		cify Yes or No	Ur	zen of What (	•	
036	4 within 72 hours after death with the Maryland liene. r then "natural", or Items 23a or 28a-f show the Medical Examinar must be mailled at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 D Yes 2   If Yes, Give Year or Date	s? ⊒No		fYes, spe 1 ☐ Yes		Specify:	, Puerto I	cify Yes or No Rican, etc.)		Black, Wh		
21215-0036	within 72 he iene. Than "natu	Completed	15. Decedent's (Specify only highest g			16a. Dece (Give life.	kind of wo DO NOT u	ork done d se retired)	uring most	of workir	ng		nd of Busines		
and 2	be filed Ital Hyg od othe event,	Be	12 Years 17. Father's Name (First, Middle, Las Emil Lengra			LC	ngsh	orema	18. Mothe		(First, Middle,	Maiden	Sumame)	Trade	Assoc
Maryland	S D E E	To	19a. Informant's Name/Relationship Mrs. Laura C. L	(Type, Print)	Wife)				nd Numbe	r or Rura	Route Numberalk, Ma	er, City o	r Town, State	, Zip Code) 222	
Baltimore,	Pages 1 and 2 nent of Health a int: If item 27 is iry or other trav		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Special Control of C		ite	Place of Disponentery, cremetery, cremetery	natory or o	other place	.		ate /2005			or Town, State Marylar	nd
Balti	permit. Pages Department of Important; If is any injury or once.		21. Signature of Funeral Service Lice	- Ma	ssee	1 7	922 1	Vise	Ave.	Dur	Home of	Mary		Inc. 21222	
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List online limediate Cause (Final disease or condition resulting in death)	a	n line.	ous c					r respiratory ar		RYNX	Approxima Interval Bi Onset and	etween
8760, 7	cate be executed oblysician and the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq										
.O. Box 6	the death certifi y the attending p iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1□Live birth 4□Pregnant 9□Unknowr	2 ☐ Feta t at time of d	I death 3	Ectopic pa Other (sp						23d. Date of d Month	lelivery Day	Year
rds, P	sign d be	by	Part II. Other significant conditions	contributing to deat	but not res	ulting in the u	nderlying o	ause give	n in Part I.			obacco u /es 2[		to the cause of Probably 4	
Vital Records,	The law ate hat b page 2 sl	Completed									24a. Was autop perfo 1 \( \text{Yes} \)		24b. Were a prior to death?		s available cause of
of	Attending Physician: 1 r death. ector: After this certifical oy the funeral dijector, p	ition: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigating	28a. Date of li (Month,		ER/Outpatien 28b. Time of Injury		28c. Injury Work	r. 4 🗆 Nur	sing Hom	Check only one 5 Residence 8d. Describe h	lence (		pecify)	
Division	in Direct	Certification	3 Suicide 6 Could not determine	28e. Place of	Injury - At he etc. (Specif	ome, farm, str	eet, factor	y, office		2	8f. Location (S City or Tox	Street an yn, State	d Number or I	Rural Route Nu	m <i>ber</i> ,
	HOS TUT A	edical	29a. Certifier 1/2 Certifying F (Check only one) 2 Medicel Exe	hysicien: To the be miner: On the basis and manner	s of exa <i>m</i> ina	wledge, death tion and/or in	occurred vestigation	at the time, in my op	e, date and inion, deatl	l place, a h occurre	nd due to the o	cause(s) date and	and manner a place, and di	as stated. ue to the cause	(s)
)	To the within 2 To the complet	W	29b. Signature and title of certifier	June	_	<b>-</b>		c. License		34				nth, Day, Year)	os
4	;+1		30. Name and address of person who	FINLL	ANT	€ 550	Print)	chin	s Bu	Yilk	Scirck	Ba	to md	6,20 HZ24	
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. egi	strar's Signa	& A	and the	6	fast	)					

			For State Registrar			nd / Depa		t of He	ealth an	d Mental		2005	167	47
П	Physici	an	1. Decedent's Name (First, Middle 109EPH R. L	e, Last) DUDEN						2. Date o	Da	y Year	3. Time of I	_
3	/Medio	al	4a. Facility Name (If not institution		r)		4b. City.	Town, or L	ocation of D		2.20	05 : County of Death	12:00	Рм
	Exami	e		AUS PARK				mori		Joan		NA		
	Funeral		5. Social Security Number		ge (In yrs	. last birthday)	If Under Months		If Under 24	Hrs. 8. Date o	f Birth Day, Year	9. Birth	place (State or intry)	Foreign
	Director		215.86.2619 Usual Residence of Decedent	IEFM 2DF	40	Yrs.				11-16	-196A		MD	
	yland iow		10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City	y Limits
	the Marylar 28e-f show	ctor	A am	A	BAL	TIMOR	E						1 🔼 Yes	2 🗌 No
	death with the Maryland ms 23a or 28e-f show rrout be netified at	Funeral Director	10e. Street and Number	<b></b>			10f. Zip				10g, Ci	tizen of What Cou	intry?	
	s 23a	eral		FALLS PARK		10 40		1215		0.10		USA		
(0	after dea or Items or iner m	Fun	11. Marital Status  1 ☑ Never Married 2 ☐ Married	12. Was Deceder Armed Forces ried 1 ☐ Yes 2 ₽	?	4			, Mexican, P	? (Specify Yes o uerto Rican, etc.	)	14. Race - Amer Black, White		
03	72 hours after naturel', or Ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1 ☐ Yes 2	2 <b>⊠</b> No	Specify:			Specify: B4	ACK	
215-0036	72 hours "naturel",	Completed	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Deced (Give	dent's Usua kind of wor	l Occupat k done du	ion Iring most of	working	16b. K	(ind of Business/Ir	ndustry	
212	within ene. than "	duc	Elementary/Secondary (0-12) IO 1H GRADE	College (1-40	r 5+)	CARPE	_	-			SFI	F EMPLO	VED	
	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle,			0,111, 2	21 0 1 -10		18. Mother's	Name (First, Mi			3.25	
ylar	should be filed withir od Mental Hygiene. marked other than matic event, Ire M	To E	WILLIAM JOHN	80N				(	JEAN	LOUDE	N			
Maryland	12 sho h and 7 Is m ireum		19a, Informant's Name/Relations	hip (Type, Print)			-					or Town, State, Zi	p Code)	
	iges 1 and 2 should be filed within 72 hours after death with fhe Maryla for Health and Mental Hygiene. If item 27 Is marked other than "naturel", or Items 23a or 28e-f shou or other treumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b.	2544 Place of Dispo	sition (Nan	ne of	10	BALIC		ocation - City or T	Own. State	
Baltimore,	Pages enf of nt: If if		1 ☐ Burial 2 🗷 Cremation  4 ☐ Donation 5 ☐ Other (S	3 ☐Removal from Stat	е _	cemetery, crer EENMO	natory or or	ther place,		. 19.05	BAL	•		
alti	permit. Page Department o Importent: If any injury or once.		21. Signatur of Funera Service		Cin			d Address		FUNER				
8	Dep Imp		23a. Part1. Enter the disease, or	. Oh		51	51 BA	MO. V	JATL F	PIKE, BA	LTO. M	10 2122	?	
68760,	ate be executed //Medical Examiner transit the burial-transit the burial-transit transit Ical Examiner	shock, or hear failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underfying Cause (Disease or injury that initiated events resulting in death) Last	a	s a consec	Quence of):	Æ	44	و	Di e			Interval Betw Onset and D	eath	
P.O. Box	The law requires that the death certificate be executed tile has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ∏ Feta at time of a	al déath 3 death 5 death	Ectopic pro Other (spo	ecity)	ı in Part I.	23e. [	-	23d. Date of delive Month	Day Ye	ear
rds	w requires been sig should bo	ed b								_	l€ Yes 2	□No 3 ☐ Pro	bably 4 20r	nknown
Records,	law re las be	Completed									Mas an autopsy	24b. Were auto	opsy findings a	vailable use of
E B	: The cate h	Con									erformed?	death?		
Vital	Physicien: this certificatal director,	Be	25. Was case referred to medica examiner?	Hospital:			_/	Othor		Death Check of				
of	g Physer this eral di	n: To	1 ☐ Yes 2 ZNo 27. Manner of Death	28a. Date of In (Month, D		ER/Outpatien 28b. Time of		A Bc. Injury a	4   Nursii		Residence ibe how inju	6 ☐Other (Speci ry occurred	fy)	-
ion	Attending ir death. ector: After by the fune	atlo	1 Accident 5 Pendir investi	gation	ay rear)	Injury	М		es 2□No					
Division	or Atter de lirecto	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 286. Place of I	njury - At h etc. <i>(Speci</i>	nome, farm, str	eet, factory	, office		28f. Location City of	on (Street ar Town, State	nd Number or Run e)	al Route Numb	er,
	spitel o	I Ce	29a. Certifier 1 Certifyin	D Physician: To the hea	et of my kn	ovladae doath		né éla a áise a	data and a	lean and due to	Ala	\d		
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only one)	ig Physician: To the bes Examiner: On the basis and manner:	of examina	ation and/or inv	estigation,	in my opir	nion, death o	occurred at the ti	me, date an	, and manner as s d place, and due t	o the cause(s)	
	To the within To the Comp	Me	29b. Signature and title of certifie		2	1	29c	License i	number		29d. Da	te signed (Month,	Day, Year)	
•				JEN8/	1	$\sim 70$		0:	53	920	5	117	05	
	2		30. Name and address of person	who completed cause of	death (Ite	m 23a) (Type,	Print)	- 1	6	5, 12 c	1	() =	170	1
	Sta	te "	31. Date filed (Month, Day, Year)	32. egis	trar's Sign	ature	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			, , , ,	Acre	24 6		1
	Registr		MAY 1	8 2005	48.3	B. So	aste)	5						

			For	State of Marylan				Mental Hyg	giene	
			For State Registrar	<del> </del>	Ce	rtificate of	Death		Reg. No.	5 16748
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day '	3. Time of Death
	/Media		4a. Facility Name (If not institution, give	LORENZ		4b. City, Town, o	or Longtion of Do	5	4c. County of	5 1421 M
	Examir	ier	University of Mary 1		- terres	RAIN	MORE	aui	4c. County of	Death
	Funeral		5. Social Security Number 6. Se			If Under 1 Year	If Under 24 H		h i	9. Birthplace (State or Foreign
	Director		220-76-0342	□ M 2 🕮 46	Yrs.	Months Days	Hours M	in. (Month, Day Nov. 10	, 1958 M	aryland
	D		Usual Residence of Decedent  10a. State 10b. County	10c Cib	/. Town or Lo	antion.				
	shor	'n	,			Cation				10d. Inside City Limits 1 ☐ Yes 2X No
	28a-f	ect	Maryland Anne Aru	ındel A	Arnold	10f. Zip Code			10g. Citizen of Wh	
	4 within 72 hours after death with the Maryland jiene. r then "neturel", or Items 23e or 28a-f show It a Medical Exar, it wit must be multifued at	Funeral Director	346 Candle Ridge	Drive		21012	)		U.S.A.	at Oodinay !
	ms 2	Jera	11. Marital Status	12. Was Decedent Ever in U.	S. 13.			(Specify Yes or No- erto Rican, etc.)		American Indian,
9	or Ite	E E	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give		ir Yes, specify Cub 1 ☐ Yes 2 🛣 No	an, mexican, Pu Specify:	erto Hican, etc.)		White, etc. White
21215-0036	urel',	d by	3 Widowed 4 Divorced	Year or Dates:					Specify:	wiiite
5	"net	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of v	vorking	16b. Kind of Busi	ness/Industry
12	within ene. then "	щ	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	u)		Own Ho	me
9	E 4 4 1	Be C	17. Father's Name (First, Middle, Last)	1			18. Mother's N	lame (First, Middle,		
<u>lan</u>		ToB	William Corson				E1ma	Finger		
Maryland	0 8 8		19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Numbe	r, City or Town, S	ate, Zip Code)
	1 and 2 Health tem 27 l		John Lorenz	Husband	346	Candle Ri	ldge Dri	ve; Arnol		and 21012
Baltimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐		ace of Dispo emetery, crei	sition (Name of matory or other pla	· 1	Date		ity or Town, State
Ë	it. Pa rtmer rtant: njury		*4 □Donation 5 □Other (Specify 21. Signature □ 10 11 Service Licen			sh.Cremat		22-2005	Laurel,	Maryland
Ba	permit. Pages Department of h Important: If ite any injury or of		21. Signature ST OF N S Street Licen	1/11290	)	Sterling	3 Ashton	Schwab F	uneral H	ome, Inc.
			23a Part1. Enter the disease, or comp	olications that caused the death		/30 Edino	mason A	venue; cat	<u>onsville</u>	Approximate
E.	Priysician		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	· C					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a consequ	uence of):					
	Examiner		Sequentially list conditions	b. COPP	7					
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
	and and I-trans	Examiner	cause. Enter Underlying that initiated events resulting in death) Last	c. Due to (or as a consequ	rence of):					
60,	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai E			20.100 01).					
68760	ficate physics the	edic		d						
Вох	leath certific attending p	Z/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		75			23d. Date	of delivery
	death	lcla	in the past 12 months?	1 Live birth 2 Fetal		_Ectopic pregnanc Other (specify) _	у		Monti	n Day Year
P.0	that the de led by the a detached f	Physician/Med	9 Unknown	9 Unknown						
	res tha igned be dei	by	Part II. Other significant conditions co	ontributing to death but not resu	alting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
Records,	v require been si should b	Completed						-		
3ec	e law has t je 2 s	m p						24a. Was a autop: perfor	SV Dri	ere autopsy findings available or to completion of cause of ath?
<u>a</u>	icien: The certificate ha	e Co	25. Was case referred to medical					1 ☐ Yes	2 1 No 1	Yes 2 No
Vital	Physicien: this certificatel director,	o B	eyaminer?	Hospital:	EB/Outpatier	nt 3 DOA Oth		eath <i>(Check only or</i> Home 5 \to Resid		(Specific)
J Of		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at		ow injury occurred	
io	Attending r death. sctor: After by the fune	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		тцагу		Yes 2 □ No			
Division	after death after death Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	Hospital of hours af Funerel D Funerel D (ely filled in		200 0 at 1 at 1 at 1 at 1 at 1 at 1 at 1	Table to the state of the state				1		
	Hos 24 ho Fun Fun	Medical	(Check only 2 Medical Exam	ysician: To the best of my know iner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my o	opinion, death oc	curred at the time, o	iate and place, an	d due to the cause(s)
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Me	29b. Signature and title of certifier		•	29c. Licens	se number	2	29d. Date signed (	Month, Day, Year)
	~/		· ///t			All	412/04	3501100	5/15/01	
1	118		30. Name and address of person who o	completed cause of death (Item	23a) (Type,	Print)	(17 47	1)114015	J. 1/1/	
	1		You war	WALL	22.	South Gro	u S1 B1	1277 we	m 2/20	11
	Sta Registr	73	31. Date Hear (Month, Day, Year)	completed cause of death (Item	ture	pode				
		120	1417 ( 3 - 22							

Division of Vital Records, P.O. Box 68760,

		_ For	State of Maryland	/ Depa	artment of H	lealth and N	Mental Hyg		gible.	16749
Physici		1 - State Registrar #1  1. Decedent's Name (First, Middle, Last)  EUDICE	8 per th g843 ! N.	<del>5/18/</del>	<del>'O5 JII</del> LEHMAN		2. Date of Dea Month		Year 2005	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give s SIPW HOGD FAU OS	treet and number)		4b. City, Town, o	r Location of Death			nty of Death	
Funeral Director		Social Security Number 6. Sex	M 2 F 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth APR. 6, 1	929	9. Birth Cou	place (State or Foreign
with the Maryland sor 28e-f show	ior	Usual Residence of Decedent  10a. State 10b. County  MD N/A	10c. City, T		cation IMORE					10d. Inside City Limits 1 X Yes 2 □ No
23a or 28e-	I Director	10e. Street and Number 3415 CLARKS LANE	#F-1	DALL	10f. Zip Code	21215	1	0g. Citizen	of What Cou	ntry? USA
after des	by Funeral		2. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	)	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ※ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		lace - Ameri lack, White, cify:	
	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 1 completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired NTEER COC	during most of work ()	ring	16b. Kind of		
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "any injury or other traumatic evant, the Megones.	To Be C	17. Father's Name (First, Middle, Last)  JACOB		NOAH	SON	18. Mother's Nam		Maiden Sum	ате)	ARONOVITZ
and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationship (Type BERNARD H. LEHMAI	/ HUSBAND	3415	CLARKS L		BALT	: City or Tov IMORE		
Pages 1		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Re  `4 ☐ Donation 5 ☐ Other (Specify)	moval from State ceme	SHAL	sition (Name of natory or other plac OM MEMOR]	AL 05/1	7/2005		STERST	OWN, MD
permit. Depart Import any inj		21. Signature of Juneral Service License	Cuttle	8	900 REIST	ss of Facility SO ERSTOWN	ROAD - P	IKESV		
Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)  5. unfaily fat condition if any, leading to immediate cause. Enter 'Underlying Cause (Disease or injury)	ations that caused the death. Ce cause on each line.  Metastatic  Due to (or as a consequence)  Due to (or as a consequence)	par				est,		Approximate Interval Between Onset and Death
ficate be executed physician and is the burial-transit	edical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequent	ce of):						
The law requires that the death certificate tte has been signed by the attending physoage 2 should be detached for use as the	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de: 4 Pregnant at time of death 9 Unknown	ath 3 [	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
quires that n signed b		Part II. Other significant conditions cont	ributing to death but not resultin	g in the u	nderlying cause give	en in Part I.		acco use co es 2□No		he cause of death?
	Completed by	MRSA SEPRIS W	ith osteomi	pelit	~S		24a. Was all autops perform	y		psy findings available mpletion of cause of
g Phy er this eral d	atlon; To Be	27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28t	Outpatien b. Time of Injury	28c. Injury Work	4   Nursing no	h (Check only on ome 5 ☐ Reside 28d. Describe ho	nce 6 🗆 C		y)
To tha Hospital or Attandin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				28f. Location (Sti City or Town	, State)		
tha Hosp nin 24 hou the Fune npletely fii	Aedical	one)	cian: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or inv	restigation, in my or	pinion, death occur	red at the time, da	ate and place	e, and due to	the cause(s)
5 til V	Σ/	29b. Signature and title of certifier    July 24-Ne	ienton M	0	29c. License			9d. Date sigr MAY	•	
)11		30. Name and address of person who con	repleted cause of death (Item 23:	a) (Type,	Print) One	5-00 (Julio	unnek	ente	n, M	(0)
Sta Registra	_	31. Date filed (Month, Day, Year)  MAY 1 8 2005	22. Registrar's Signature	Sou						

	1 - For State Registrar		Maryland / De <sub>l</sub>	partment of Hertificate of L		Reg	g. No 200	1675
Physician /Medical Examiner		L € V €.	N71-1AL	4b. City, Town, or BALTIMO	Location of Death		Day Yea	T 7:30 A
Funeral Director	5. Social Security Number 219-18-7312 Usual Residence of Decedent	6. Sex 1  M 2  F 7. A	Age (In yrs. last birthda 79 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) SEP.23,1	(925 9. E	Birthplace (State or Forei Country) MD
28e-f show offined at ector	10a. State 10b. Coun	ty LTIMORE	10c. City, Town or BAL	TIMORE				10d. Inside City Limi
"natural", or items 23a or 28e-f show edical Examiner must be notified at alleted by Funeral Director	23 STONEHENG  11. Marital Status  1 Never Married 2 Mi 3 12 Widowed 4 Divorce	12. Was Decede Armed Force 1 M Yes 2	nt Ever in U.S. 13 s? □ No	10f. Zip Code  3. Was Decedent of Hi If Yes, specify Cubar 1 □ Yes 2 🛣 No	21208 spanic Origin? (Sp n, Mexican, Puerto Specify:		g. Citizen of What  14. Race - A. Black, W  Specify:	USA merican Indian,
ygiene.  her than "  t, If a Me  Compile	15. Decede (Specify only high Elementary/Secondary (0-12 10		(Gin	edent's Usual Occupa re kind of work done of DO NOT use retired, ES MANAGER	furing most of work )	king F	6b. Kind of Busine	ss/Industry
To Be				ENTHAL	BELLA	e (First, Middle, Ma		EISEN Zin Code)
permit, rages i and a Department of Health a Importent: If item 27 is any injury or other treu once.	JAY LEVENTHA  20a. Method of Disposition  1 A Burial 2 Cremation  4 Donation 5 Other  21. Signature of Fineral Service	n 3 □Removal from Sta (Specify)	8 R 20b. Place of Discemetery, cr	ANDALL AVE cosition (Name of ematory or other place MUNAH)AITZ 22. Name and Addres	NUE - BA CHAIM 5 s of Facility SO	LTIMORE, Date 20 /17/05 L LEVINSO	MD 21208 Dc. Location - City HALET DN & BROS	or Town, State HORPE, MD
nysician /Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	a. <u>COMON</u> Due to (or a	sed the death. Do not en line.  4 42 52 as a consequence of):	nter the mode of dying	g, such as cardiac			Approximate Interval Between Onset and Death
bhysician and the burial-transit		C	as a consequence of): as a consequence of):					
signed by the attending ph be detached for use as th by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of o	delivery Day Year
be d	Part II, Differ significant condi	tions contributing to death	but not resulting in the	underlying cause give	n in Part I.	1 ☐ Yes	2 No 3	to the cause of death'
certificate has been s rector, page 2 should	25. Was case referred to medic	al			26 Place of Deat	24a. Was an autopsy performe 1 Yes 24	prior t	
After this funeral di	examiner? 1  Yes 2 No 27. Manner of Death 1  Natural 5 Penc	Hospital: 1 Inpa	atient 2 ER/Outpati njury 28b. Time Day Year) Injury	of 28c. Injury Work	r: 4 ☐ Nursing Ho	ome 5 Residence 28d. Describe how		pecify)
within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification;	4   Homicide	mined 286. Place of I building,	Injury - At home, farm, s etc. (Specify)			City or Town,	State)	Rural Route Number,
within 24 hours To the Funeral Completely filled	one)	ing Physician: To the bes I Examiner: On the basis and manner	of examination and/or	nvestigation, in my op	inion, death occur	red at the time, date	e and place, and d	ue to the cause(s)
To t com		. Everely		29c. License			d. Date signed (Mo	
-(0	30. Name and address of perso	n who completed cause of Scive dere 27 32. Regis	f death (Item 23a) (Type	e, Print)	.5.25			

			1- State of Maryland / Department of Health and Mental Hygiene 0 5 675    Certificate of Death Reg. No.					
	Physici /Medic		Decedent's Name (First, Middle, Last)     VERNON	LUCI	KHARDT	2. Date of De MAY 15		3. Time of Death 7:35 P M
	Examir		4a. Facility Name (If not institution, give street and number) 728 S. ELLWOOD AVE.		4b. City, Town, or Location of Dec BALTIMORE	ath	4c. County of D	
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 18−42−0949 1	e (In yrs. last birthday) 59 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi		9. 1 25, 1945	Birthplace (State or Foreign Country) MD .
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23e or 28e-1 show any injury or other traumatic event, I'm Madical Extrinst Institute to confided at once.	rector	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
			MD . N/A	BAI	LTIMORE		10g. Citizen of What	1X Yes 2 □ No
		ai Di	728 S. ELLWOOD AVE.		21224		UNITED ST	•
		Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 □ If Yes, Give X Year or Dates:	No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☐ No Specify:	(Specify Yes or No erto Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. WHITE
21215-0036	n 72 ho netur	leted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation h kind of work done during most of w DO NOT use retired)	rorking	16b. Kind of Busine	ss/Industry
212	ed withi /giene. ier than	Comp	Elementary/Secondary (0-12) College (1-4or 5	5+)	EL WORKER		BETHLEHI	EM STEEL
Maryland	nd 2 should be fill aith and Mental Hy 27 is marked oth r traumatic even	To Be	17. Father's Name (First, Middle, Last) KENNETH LUCKHARDT		DOROTI	HY GREEN	, Maiden Sumame)	
			19a. Informant's Name/Relationship (Type, Print) LINDA LUCKHARDT/WIFE		ng Address (Street and Number or I S. ELLWOOD AVE.			
Baltimore,	iges 1 a it of Hear If item or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from State	FIRST EV	osition (Name of matory or other place) AN(1-FLTL(AT	Date	20c. Location - City	
altin	mit. Pa partmer portent: / injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of June al Service Licensee	22	CEMETERY   MAY 2. Name and Address of Facility C]			E, MARYLAND SON. INC.
ä	Depa Impo any ir	0 12	John Course		6224 EASTERN AVE	., BALTIN	MARYI	LAND 21224
	Physician /Medical Examiner	Completed by Physiclan/Medical Examiner	23a Farth. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lice. Immediate Cause (Final disease or condition resulting in death)  Due to (or as		esophagea			Approximate Interval Between Inset and Death
Division of Vital Records, P.O. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit		Se uential V list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):					
			in the past 12 months?	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify) Month Day Year				
	es pe		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  Yes 2 \( \text{N} \) 0 3 \( \text{Probably} \) 4 \( \text{Unknown} \)					
	The law requir ate has been si page 2 should					24a. Was autop perfo 1  Yes	osy prior t ormed? death	autopsy findings available o completion of cause of ?
	Physician: The this certificate har all director, page	o Be	25. Was case referred to medical examiner?  1					
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical Certification; To						
			2 Accident investigation	ury - At home, farm, str c. (Specify)	M 1 ☐ Yes 2 ☐ No  - At home, farm, street, factory, office  2  2		Bf. Location (Street and Number or Rural Route Number, City or Town, State)	
			29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  [Check only one)  [Check one)  [Check only one)  [Check only one)  [Check only one)  [Che					
)			29b. Signature and title of certifier  Nany O Daws	JM so	29c. License number  Maryland D3		29d. Date signed (Mo	nth, Dey, Year)
	10		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,			move M	D 21201
	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registr	ar's Signature		<del>۱۱۱۳ من</del>		
DHMH 17 Rev 1/2001								
				ORIGIN/	4L			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Morrison Gladstone 13 2005 May 5:15p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Future Care Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□ F Days Hours Yrs. 88 Director 217-34-4136 16 Jamaica Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits al Hygiene. I other then "natural", or items 23a or 28a-f show went, the Medical Exertines truss be notified at XIXYes 2 No **Funeral Director** MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. 2210 Dukeland Street Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 DXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Completed by Specify: ₩idowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stebbins Anderson Supply Drive 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Is marked o 2 Elizabeth Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I 2800 Windsor Ave. Baltimore, Md 21216 Elaine Houston-Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Importent: If Ite
any injury or ot Surial 2 ☐ Cremation 3 ☐ Removal from State \*4 ☐Donation 5 ☐ Other (Specify) Maryland National 5/20/05 Laurel, Md 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 29a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest phock, or heart failure. List only one cause on each line. Baltimore, Approximate Interval Between Onset and Death nediate Cause (Final **Physician** disease or contain resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner and I-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Jension this certificate DV65. 2□ No cancer 1 ☐ Yes 30 No 1 TYes 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 1 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 60/4 821 EUtaw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mil m 31. Date filed (Month, Day, Year) 32. Registrar Signature

DHMH 17 Rev 1/2001

Registrar

			. For	State of Ma	aryland	/ Depa	artment of	Health	and N	lental Hy	giene,	100	عنى <u>ۋ</u>	**** 27** // )
		_	State Registrar	-		Cer	tificate c	f Deat	th		Reg. No.	JUD	I b	153
	Physici	an	1. Decedent's Name (First, Middle,			,				2. Date of De Month	ath Day	Year	3. Tim	e of Death
	/Medic	al	4a. Facility Name (If not institution,	MIEL(	JUR		4b. City, Town	or Locatio	on of Death	5	4c Co	US unty of Death	112	:50pm
4.	Examin	er	MARINER HE	ALIH CA	TONS	Dust	-0. Olly, 104	TOALS	WILL	E		727/n	nore	=
	Funeral		5. Social Security Number		(In yrs. las		If Under 1 Ye Months Dar		ler 24 Hrs.	8. Date of Bir (Month, Da	th .	/		te or Foreign
В.	Director		218-44-1011	1 M 2□F	61	Yrs.	Months	/s Hour	S WIII.	9/15	143	1	<del>Maryla</del>	
	and wc		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation			•				e City Limits
	Mary Fied	ţ	Maryland	Howard				Ellicott	Cltv				1 🗆 🕆	res 2 No
	or 28e	Director	10e. Street and Number				10f. Zip Cod		010		10g. Citizen	of What Cou	ntry?	
	ath wi	ral	12004 Frederick Roa						1042			U.S		
	ltems	Funeral	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Armed Forces? d 1 ☐ Yes 2 🕱 1		. 13. \	Nas Decedent of Yes, specify C	of Hispanic uban, Mexi	Origin? (Sp can, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White,		١,
21215-0036	72 hours after death with the Maryland naturel; or Items 23s or 28e-f show dies! Evantreer must be redified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10		1□Yes 2💢	No Spec	ify:		Sp	ecity:	White	
5-0	72 ho	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Oc kind of work do	ne durina n	nost of work	ting	16b. Kind	of Business/Ir	dustry	
121	filed within Hygiene. Ither then "	ldu	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. I	DO NOT use re					Resta	aurant	
	filed withi Hygiene. other ther		17. Father's Name (First, Middle, L	ast)				Cook		e (First, Middle,	Maiden Sui	mame)		
an	should be and Mental is marked o	To Be	Antho	nv J. Mielock						E	velyn M	iller		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. item 27 is marked other then "naturel", or Items 23s or 28e-f show other treumatic event, The Medical Exertirer must be notified at		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	ng Address (Str	et and Nur	mber or Rui	al Route Numbe	er, City or To	wn, State, Zij	Code)	-
	of Health item 27		Ms. Shirley Mielo	ck Spous						ott City, Ma				
altimore,	0 0		20a. Method of Disposition  1   Burial 2 ACremation				sition (Name of matory or other		1	Date		ion - City or T		
Ē			<ul> <li>4 □ Donation 5 □ Other (Sp.</li> <li>21. Signeture of Funeral Service D</li> </ul>		All C	ounty C	remation S	ervices	Inc. 05/	15/2005	S	ykesville,	Maryla	and
Ba	permit. Departr Importe any inje		Moloniel	Mento	Of Par	0			,	e, P.A. <del>Pike Ellicot</del>				
	×		23a. Part1. Enter the disease, or dishock, or heart failure. List of	omplications that caused	the death.	Do not ent	er the mode of	tying, such	as cardiac	or respiratory a	t City, M rrest,	D 21043	Approxi	mate Between
	Priyaician	(C. )	Immediate Cause (Final disease or condition	. 4		arcino	ma Un	Trown	Prime	1/4			Onset a	nd Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):				d				
	- Administra	<u></u>	Se uentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	nce of:	_							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
0,	an and rial-tra	Еха	resulting in death) Last	Due to (or as	a conseque	ence of):								
8760,	cate be executed physician and the burial-transit	dical		d							· · · · · ·			
9 xo	The law requires that the death certificate be executed tate been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnance	av					224	. Date of deliv	0.004	
Bo	death atten	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal d	leath 3□	Ectopic pregnal Other (specify				250	Month	Day	Year
0	that the de led by the a detached t	hysi	9 Unknown	9□ Unknown										
s, P	res that signed b		Part II. Other significant condition		ut not result	ing in the u	nderlying cause	given in Pa	art I.		_ 1	contribute to t		
Records,	w requir been si should	Completed by	Dermatonyosit							10'		lo 3 ☐ Pro	bably 4	Unknown
Sec	e law has b	mple	Lest Sided Hyd	ronephosis						24a. Was autop		4b. Were auto prior to co death?	opsy findir Impletion	ngs available of cause of
	iicien: The lav certificate has rector, page 2		25. Was case referred to medical						( D	1 ☐ Yes	2 Z No	1 ☐ Yes	2. No	
\\	Physicien: r this certific ral director,	To Be	examiner?  1 Yes 2 No	Hospital:	nt 2∏E	R/Outpatien	it 3 DOA	Othor		th (Check only only one 5 ☐ Resident		Other (Speci	(v)	
υof	ding Physicien: The h. h. After this certificate ha funeral director, page	T:u	27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Inju		28b. Time of Injury		njury at Work?		28d. Describe			,,	
Sior	Attending r death. ector: After by the fune	catic	2 Accident investigations of Could not	ation			М :	☐ Yes 2	□No					
Division of Vital	in Lin	Certification;	4 Homicide determin		ury - At hom c. (Specify)	ne, farm, str	eet, factory, offi	CO		28f. Location (. City or Tox		umber or Run	ai Houte i	√um <i>ber</i> ,
	spitel		29a. Certifier 1 Certifying	Physician: To the best	of my know	ledge, death	n occurred at th	e time, date	and place	and due to the	cause(s) and	d manner as s	atated.	
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical		xaminer: On the basis o and manner sta	fexamination									6e(s)
	To th To th comp	M	29b. Signature and title of certifier				29c. Lic	ense numb	er 2			igned (Month,		r)
	1		Donne Ca	can 191)			114	1797			911	7/05		
10	1		30. Name and address of person w	the completed cause of d	eath (Item 2	23a) (Type,	Print)	in horse	1.110	2120	28			
W	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	r's Signatu	ire M	Scarle	1013	VILLE	0120	0			
	Regist		MAY	1 8 2005	ENELAS.	SALO"	A STATE OF THE PARTY OF THE PAR				_			

		1. Decedent's Name (First, Mi	1. Decedent's Name (First, Middle, Last)  Ann Moon							<ol><li>Date of Death Month</li></ol>		ear	3. Time of Deat
hysician Medica/				Ar	n Mo	on	,				12, 2005		12:55 a
Examine		4a. Facility Name (If not institu					4b. City, Town,	or Location		H CII.	4c. County of		ra val
		5. Social Security Number	6, Sex	1 Elko I		last birthday)	If Under 1 Year	If Under	Ellico	8. Date of Birth	9	How	
uneral rector	,	214-34-6690		2 <b>X</b> F	66	Yrs.	Months Days		Min.	(Month, Day,			ace (State or For
	-	Usual Residence of Decedent							<u> </u>	September 2	28, 1938 · 		hington, DC
d at		10a. State 10b. Cou	inty		10c. Ci	ity, Town or Lo	ocation					10	od. Inside City Lin 1 ☐ Yes 2
ba notified	2	Maryland  10e. Street and Number	Howar	ď				Ellicott C	ity	10	g. Citizen of Wha	at Count	
- A	2	8321 Elko Drive					10f. Zip Code	21	043		-	U.S.A	•
EMINE COLOR	Launeral	11. Marital Status	12. V	Vas Deced	dent Ever in U	J.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Or	igin? (Spe	cify Yes or No-	14. Race -		
1	<u>~</u>	1 Never Married 2 1 1 3 Widowed 4 Divor	Married 1	Armed Ford Yes 2 Yes, Give Year or Da	2 X No		1 ☐ Yes 2 No			Hican, etc.)	Specify:	White, e	White
ifical	Сошріете	15. Dece (Specify only hig	dent's Educatio	n n n n n n n n n n n n n n n n n n n		(Give	dent's Usual Occu	durina mos	at of workir	1 1	6b. Kind of Busir	ness/Ind	ustry
Med	d -	Elementary/Secondary (0-1		College (1-	4or 5+)	life.	DO NOT use retir	90)			Altern	ative	Education
# S		1+ 17. Father's Name (First, Mide	do (ast)				Instruc	tional As		(First, Middle, M	faiden Sumame)		
ava	ו מ		ovel Ernest	Rurton	,			10. 10001	or o reamo		thel Grav		
matic	0	19a. Informant's Name/Relati			1	19b. Mailir	ng Address (Stree	t and Numb	er or Rura			ate, Zip	Code)
r trau	-[	Mrs. Karen Mooi	n Koenia	Dau	ughter	3	313 Oella Av	e Caton	sville, N	Maryland 21	228		
otha	-	20a. Method of Disposition			20b.	Place of Dispo	osition (Name of matory or other pl	ace)	D	ate 2	0c. Location - Ci	ty or Tov	wn, State
Iry or		Burial 2 Cremati		oval from S	state	•	n Memorial	1	05/	16/2005	Marriott	tsville	, Maryland
any inju		21. Smatur S Funera Serv	icensee	leh	- Ma	25 25	2. Name and Add	Funeral	Home.	P.A.	City, MD 21	042	
		23a. Part1. Enter the disease thock, or heart failure.	e, or complication	ons that ca	used the dea	4h D	30 / I	JIG COIL	cardiac o	r respiratory arre	City, IVID 21		Approximate
ician					ch line	ith. Do not en	ter the mode or dy	ing, such as	oardiac o	r respiratory arro	SI,		Interval Between
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edical		Impediate Cause (Final difease or condition resulting in death)	a	met	ach line.	ric	4-			n ced	st,	2	
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The Funeral Director: After this certificate has been signed by the attending physician and planting the priorities of the priorities of the burial-transit of positions in the funeral director, page 2 should be detached for use as the burial-transit of positions in the priorities of the priorities o	Medical Certification: 10 Be Completed by Physician/Medical Exal	difease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant con  25. Was case referred to me examiner? 1   Yes 2   No 27. Manner of Death   Natural   S   Pe   Accident   S   Pe   Accident   S   Pe   Accident   S   S   Pe   Accident   S   S   Pe   Accident   S   Accident   S   Accident   S   Accident   S   Accid	dical Hosp  anding vestigation buld not be stermined 2  tifying Physicial ical Examiner:	Due to (control of the property of the propert	or as a consector as	quence of):  quenc	By 24  Bot 24  Cither (specify)  Inderlying cause good and a specific pregnant of the course of the occurred at the envestigation, in my 29c. Lices and the course of the occurred at the	26. Place ther: 4 \( \text{N} \) Nury at ork? \( \text{Yes} \) 2 \( Lime, date a opinion, de	e of Death ursing Hor	23e. Did tob  1  Ye  24a. Was ar autopsy perform  1  Yes  2 (Check only one me 5) Resider  28d. Describe hore  28f. Location (Str. City or Town.  and due to the called at the time, dat	23d. Date of Month accourse contributes 2 No 3 2 No 3 2 No 1 2 No 1 2 No 1 Double of the contributes and Number (State)	of deliver  ute to the Proba  re autopor to com Yes  (Specify)  or Rural are as sta d due to	Onset and Deal  Try Day Year  e cause of death ably 4 Dunkr  by findings avainpletion of cause 2 No  1 Route Number, ated. the cause(s)

**Funeral** Director

> Pnysician /Medical

attending physician and for use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760 the à Division of Vital Records. pe cate has been sig page 2 should b certificate After this c

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 2. Date of Death Decedent's Name (First Middle Last Month Year **Physician** Q M Raymond Ε Marousek 05 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Franklin Square
5. Social Security Number Baltimore Hospital
6. Sex hose da le If Under 1 Year | If Under 24 Hrs. 1161 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Min 1 ☐ M 2 ☐ F Months Days Hours 217 05 1925 86 December 21 1918 Baltimore City, Mil Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 7 ie marked other then "neturel", or Items 23e or 28a-f ehow treumetic event, 'ne Medical Examinat must be nutillied at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 105 Fuller Avenue 21206 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. illed within 72 hours after Affiled Folces: 1 Types 2 No If Yes, Give Year or Dates: W II 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within the sent of Health and Mental Hygiene. NΑ Painter Local Union 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank J Marousek Mary Baroch 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hilda C Marousek 105 Fuller Avenue Baltimore, Md. 21206 item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If it eny injury or o 1 XBurial 2 Cremation 3 Removal from State Parkwood Cemetery May 16 2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Hone Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia disease or condition resulting in death) Examiner the spiratory failure Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 18 No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 0 1 ☐ Yes 2 K No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO AF-2325412-4104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Alexande 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001

			_ FOI	artment of Health and Mo		ne 2005	16756
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Lorraine C Miller		2. Date of Death	Day Year 2005	3. Time of Death 6:15 A M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number)  205 Tyson Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 218–14–1234 1 M 2 F 81 Yrs.	4b. City, Town, or Location of Death  Ellicott City  If Under 1 Year   If Under 24 Hrs.    Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 11,	4c. County of Death Howard  9. Birthpl County 1924 Mary	ace (State or Foreign try) Land
10	be filed within 72 hours after death with the Maryland tall Hygiene. Id other then "natural", or Items 23e or 28e-1 show avent, I're Madical Exterit are restlicted at	Funeral Director	10e. Street and Number  8205 Tyson Road  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	tt City  10f. Zip Code 21 042  Was Decedent of Hispanic Origin? (Sperif Yes, specify Cuban, Mexican, Puerto F		Citizen of What Coun USA  14. Race - America Black, White, 6	an Indian,
N	filed within 72 hours al Hygiene. other then "natural", or ant, Ire Modical Exer-	Completed by	3 ☑ Widowed 4 □ Divorced	adent's Usual Occupation be kind of work done during most of working DO NOT use retired)  ical Secretary  18. Mother's Name	ng	c. Kind of Business/Ind	ite
Maryland	2 should and Mer Is marke aumatic	To Be		Elizationg Address (Street and Number or Rural	eth I Route Number, C	Weaver	
Baltimore, N	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 2069.		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4  Donation 5 Other (Specify)  21. Sign fure of Fuller IS rvice Lightsee  22. Characteristics are a second of the second of th	osition (Name of productory or other place)  Service Corp. 5/17  22. Name and Address of Facility  Ruck Towson Funeral	ate 2007/05 Ti		<sub>wn, State</sub> /land rk Road Md.21204
	Dhysician and physician and physician and the printer than sill the printer than sill the printer than sill than sil	dical Examiner	23a. Part 1. Enter the disease, or complications the caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Social fairly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):	tion ge seniledeme			Approximate Internal Batween Onset and Death
O. Box	the death certificate b by the attending physic ached for use as the b	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
of Vital Records, P.	sician: The law requires that the death certificate be executed scertificate has been signed by the attending physician and lirector, page 2 should be detached for use as the burial-transit	Completed by	Parli. Other significant conditions contributing to death but not resulting in the huper fension  peripheral Vascular discuse emphysema		1 Yes  24a. Was an autopsy performer 1 Yes 2	prior to con	ably 4 Unknown osy findings available npletion of cause of
Division of Vit	or Attending Phy Iter death. Director: After this in by the funeral d	Certification; To Be	25. Was c - e refer d to medical examiner?  1	of 28c. Injury at Work?  M 1 Yes 2 No	ne 5 🗌 Residence 28d. Describe how	injury occurred  at and Number or Rura	Facility
_	To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dear and manner stated.  Certifying Physician: To the best of my knowledge, dear and manner stated.	ath occurred at the time, date and place, a nvestigation, in my opinion, death occurred 29c. License number	ed at the time, date	se(s) and manner as st and place, and due to Date signed (Month, I	the cause(s)
•	P S S S S S S S S S S S S S S S S S S S		30. Name and address of person who completed cause of death (Item 23a) (Type 606 Hammond's Cane. S	061785	2	113/05	
DH	Sta Regist	<u>:</u> .	31. Date filed (Month, Day, Year)  MAY 1 8 2005  ORIGIN	leeli	right.		

		State     Registrar     Decedent's Name (First, Middle, Last,		Cert	tificate of	Death	Re 2. Date of Death	g. No. 20	3. Time of Dea
Physici /Medio Examin	cal	Pear1  4a. Facility Name (If not institution, give	E.		•	or Location of Deat	May 11	Day 2005	9:35A
uneral irector		26407 Morganza Tt  5. Social Security Number 578-40-0177 6. Security Number		ast birthday) _ Yrs.	Med If Under 1 Year Months Days	hanicsvi	8. Date of Birth	Charl 1931	es 9. Birthplace (State or For Country) Washington I
other than "natural", or items 23a or 28a-f show ovent, the Modical Examiner must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Go  10e. Street and Number		, Town or Loc	ation per Marl	boro	10	og. Citizen of W	10d. Inside City Lir 1 ☐ Yes 2 ☐
s 23a or		9022 Columbin		10.40	2077			U.	S.A.
al', or Itam Examinar n	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 MNo If Yes, Give Year or Dates:		Yes, specify Cub		Specify Yes or No- to Rican, etc.)	Black	White etc.
Medical	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give k life. D		pation during most of wo d)	orking 1	6b. Kind of Bus	·
	To Be Cor	17. Father's Name (First, Middle, Last)  Joseph Le	vy	Wrapp	er	18. Mother's Na Laura	me (First, Middle, M Denniso	laiden Sumame	ndustry
itam 27 is marke other traumatic	-	19a. Informant's Name/Relationship (7) Barbara Windsor (1	Daughter)	2640	6 Anne C	Ct. Mecha		, Maryl	and 20659
Important: If itan any injury or oth once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service I cens	Mar	yland 22.	ition (Name of atory or other pla Veterans Name and Addre	s Cem. 2	005 C Lee Funer	heltenh al Home	City or Town, State nam, Maryland e, Incinton, MD207
attending physician and ledical for use as the burial-transit	dicai Examiner	23a. Pert 1. Enter the disease, or compishook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ence of):	HEART CARDIO	FARILD Myofa Tu	RE Y		Interval Between Onset and Death
y the attending ched for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ect <i>o</i> pic pregnanc Other <i>(specify)</i> _	у		23d. Date Mon	e of delivery hth Day Year
been signed by the should be detached		Part II. Other significant conditions co	ntributing to death but not resu	ılting in the un	derlying cause gr	ven in Part I.			ibute to the cause of death
SC	Completed						24a. Was ar autopsy perform 1 Yes 2	/ Hg-d? di	Vere autopsy findings avail rior to completion of cause eath? ☐ Yes 2☐ No
aur. rr: After this certificate ha ne funeral director, page	ation; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1  Inpatient 2  I	ER/Outpatient 28b. Time of Injury	28c. Inju	her: 4 Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	nce 6 V he	ughter's sidence
within 24 flours area locali.  To the Funarat Diractor: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	′)			City or Town	, State)	er or Rural Route Number,
N N	Medical	29a. Certifier (Check only one)  25 Medical Examone)  29b. Signature and tifle of certifier	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	estigation, in my	ime, date and place opinion, death occurrence occurrenc	curred at the time, da	te and place, a	and due to the cause(s)  I (Month, Day, Year)
To the Fi								1	

DHMH 17 Rev 1/2001

ORIGINAL

GEORGE MITCHELL 05-03362 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RKD State of Maryland / Department of Health and Mental Hygiene G843 5-25-05 tas

Registrar

State of Maryland / Department of Health and Mental Hygiene G843 5-25-05 tas

Reg. No. Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** George E. Mitchell MAY 14 2005 11:04P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2□F Yrs Director Md 215-16-3396 48 Nov 15, 1956 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f show other traumatic event, the Nedical Exercit er must be notified at Y⊟Yes 2 No **Baltimore** Director N/A Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21229 607 Nottingham Road Itema 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify Black 3 € Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unk Unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in nent of Health and Mental I Shirley Ann Cherry George E. Mithcell Sr. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1618 1/2 North 5th Street Harrisburg, Pa. 17102 item 27 I Washula Nesbitt Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Ξ 0 permit. Page Department of Important: If any injury or once. 05/20/05 Baltimore, Md. \*4 ☐ Donation 5 ☐ Other (Specify) Western Star Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estap Brothers Funeral Service 1300 Eutaw Place Baltimore, Maryland 21217 23a. Part1. Enter the disertie, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heroin intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) Division of Wifal Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 No 24a. Was an autopsy performed? 1ZYes 2□ No 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 in by the funeral dir 28b. Time of **unk** 28c. Injury at Injury 28a. Date of Injury **Found**, Day Year) **5-14-05** unk 27. Manner of Death 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 X No s after death 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1223 Smithson St. determined 4 Homicide Scene Balto., Md within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number OCME 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier nes MAY 16, 2005

State

Registrar

Penn Street Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

RNB10

ANA

31. Date filed (Month, Day, Year,

State of Maryland / Department of Health and Mental F  1- For State Registrar  Certificate of Death	ygiene Reg. No. 0 0 5 1 6 7 5 9
1. Decedent's Name (First, Middle, Last)  2. Date of	Death 3. Time of Death
Physician John Walter Mitchell Jr. April	27,2005 12:15 <sub>pm</sub>
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
6749 Animal Shelter Rd Hughesville  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs. 8. Date of 1	Charles
Funeral Months Days Hours Min. (Month,	Birth 9. Birthplace (State or Foreign Country)
Usual Residence of Decedent	er 22,22 Maryland
To a State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10a. State   10b. County   10c. City, Town or Location   10c. City or Location   10c. City or Location   10c. City or Location   10c. City or Location   10c. City or Locat	10d. Inside City Limits
Maryland Charles Hughesville  106. Street and Number 107. Zip Code	1 ZXYes 2 □ No
10f. Zip Code	10g. Citizen of What Country?
6749 Animal Shelter Rd 20637  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 IXYes 2 No 15. No 15	USA No- 14. Race - American Indian,
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
If Yes, Give 1 ☐ Yes 2 ☒ No Specify:	Specify: Black
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  12  Truck Driver	16b. Kind of Business/Industry
College (1-4or 5+)  Elementary/Secondary (0-12)  1 2  College (1-4or 5+)  Truck Driver	
Elementary/Secondary (0-12)  1 2    College (1-4or 5+)   Truck Driver   Truck Driver   18. Mother's Name (First, Middle, Last)	Federal Government
Ta a me position of the second	Butler
See The See Th	
10a. State   10b. County   10c. City, Town or Location	
Truck Driver    Specify   1   1   1   1   1   1   1   1   1	20c. Location - City or Town, State
*4 Donation 5 Other (Specify) MD Veterans Cem. 5-5-05	Cheltenham, MD
21. Signature of Funeral Service Licensee 22. Name and Address of Facility	•
191 Adams Funeral Home.PA	Aquasco,MD 20608
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one-cause on each line.	arrest, Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death)  Amedical Immediate Cause (Final disease or condition a. Due to (Year a general group of file)	Chisti and Scalin
Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
Due to (or as a consequence of):  cause. Enter Underlying Cause. (Disease or in flury) that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
resulting in death) Last  Due to (or as a consequence of):	
datase. Enter Ordering Causa (Disease or Fingly that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d. Due to (or as a consequence of):	
W IF FEMALE:	
YOUR STANDARD STANDA	23d. Date of delivery  Month Day Year
TF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	
	tobacco use contribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Yes 2 No 3 Probably Cnknown
24a. We authorise to the property of the prope	s an 24b. Were autopsy findings available
Age of the control of	prior to completion of cause of death?
	2☐No 1☐Yes 2☐No
2 5 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	sidence 6 Other (Specify)
27. Manne of Death 28a. Date of Injury 28b. Time of lingury 28b. Time of lingury 28c. Injury at lingury 28d. Describ	how injury occurred
To be seen to be seen	
27. Manne of Death 1 Plate of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describ 1 Plate of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describ 1 Plate of Injury Month 1 Plate of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No 28b. Time of Injury Month 1 Plate of Injury Month	(Street and Number or Rural Route Number, own, State)
2 S 6 0 0	Cause(s) and manner as stated
29a. Certifier (Check only one)  29a. Certifier (Check one)  29a. Certifier (Check only one)  29a. Certifier (Check one)  29a. C	, date and place, and due to the cause(s)
E > E O 1 W /	
29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Dey, Year)
29b. Signature and title of certifier  PACE  29c. License number  DDF Z 5 2	29d. Date signed (Month, Dey, Year)
29b. Signature and title of certifier  29c. License number  D + 2 5 2  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29d. Date signed (Month, Dey, Year)
bouse 7 Maller D28252	29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:40 p Jernita Laura Matthews М May 11, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severn 651 Queenstown Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🖸 F Director 213-22-1970 84 Apr 27, 1921 Md Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The short of Health and Mental Hygiene and it if them 27 ie marked other than "natural", or iteme 23a or 28a-1 show and it if the Medical Explaims or minit be invilled at ury or other traumatic avent. The Medical Explaims of minit be invilled at 10a State 10c. City Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director Md Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 651 Queenstown Road 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 YNo Specify: Completed by Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grant Gaither Laura Gaither 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 651 Queenstown Road Severn, Md. 21144 Ronald Matthews Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages
Department of
Important: If any injury or
once. 05/18/05 \* 4 ☐ Donation 5 ☐ Other (Specify) Hanover, Md. St. Rest Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service PA 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 glen disease or condition resulting in death) /Medical as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsersa. Due to (or as a consequence of): Physician/Medical Examiner g physician and as the burial-transit The law requires that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE 1Se . If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 20 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year, 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Vithin 24 hours arter To the Funeral Director Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of pers ed cause of death (Item 23a) (Type, Print) DEFENSE M.D. 31. Date filed (Month, 32. Resistrar's Signature State 18 2005 Registrar

Fune Direc

DIVISION OF VITAL DECOLUS, T.O. DOA 66760,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed	
wiithin 24 hours after death.	
To the Funeral Director: After this certificate has been signed by the attending physician and	ñ
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	L
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an	1 - State Registrar  1. Decedent's Name (First, Middle, Las		36		ficate of	Dealii —	2. Date of			Year	3. Time of							
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er	4a. Facility Name (If not institution, give Andrus House	e street and number)		4	b. City, Town, o		Death		4c. County Mon	of Death tgom∈	erv							
	5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last b		f Under 1 Year	If Under 2	4 Hrs. 8. Date of	of Birth		9. Birthr	place (State or							
	323-30-4207	□M 2X)F	77	Yrs.	Months Days	Hours	Min. Octobe	n Day Ye	1927	New	Mexico							
	Usual Residence of Decedent  10a, State 10b, County		10c. City, To	wn or Loca	ion						10d. Inside Cit							
ō		ierv		ville							1 🗆 Yes							
Director	10e. Street and Number				10f, Zip Code			10g.	Citizen of	Citizen of What Country?								
0 0	14310 Woodcrest	Drive			2085	3		United States										
Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Wa	s Decedent of H	lispanic Orig	in? (Specify Yes of Puerto Rican, etc	or No-		ce - Americk, White,	can Indian,							
by Fu		1 ☐ Yes 2 💥 I If Yes, Give Year or Dates:	No		Yes 2∏ No			•	Specif									
		16	16a. Decedent's Usual Occupation					o. Kind of B		nite								
Completed	(Specify only highest gra	(Give kir	d of work done NDT use retire	during most	of working	100	, Killd of B	usiness/in	dustry									
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BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)									пе)								
To E	Alfred Willis Cu	rnow				Ire	ne Boldt											
	19a. Informant's Name/Relationship (						or Rural Route N											
	Melissa I. McKer	row/Daught			on (Name of	St Dr	ive, Rock	-										
	20a. Method of Disposition  1   Burial 2   Cremation 3		cemet	ery, crema	ory or other pla	œ) ¦Ма	ay 19,		Location									
	*4 □Donation 5 □ Other (Specify	1	Montgon	00 1	ematorium	4 = 104	2005	_			Marylan							
	21. Signature of Fluneral Service Liber	1001/10	101420	Rob 300	ert A. Pu West Moi	mphrey itgomer	Funeral H	ome/Ro kockvi	ckvill	e, Indarylar	id 20850							
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each li	ne.		he mode of dyi ht Femu		ardiac or respirat	ory arrest,			Approximate Interval Betw Onset and D 3 Year							
	resulting in death)		a consequence								0							
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dical		d																
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hysiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deal		topic pregnancy ther (specify) _	,			23d. Date of delivery Month Day Year									
Д.	Bod II Other eignificant conditions o	contributing to death b	ut not resulting	in the unde	orlying cause gr	en in Part I.	23e.	Did tobace	co use con	tribute to t	he cause of de							
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d by							24a.	Was an	24b.	Were auto	psy findings a							
								autopsy performed	1?	prior to co death?	mpletion of ca							
	25. Was case referred to medical					26 Place			No	1 🗌 Yes	2U NO							
e Completed	25. Was case referred to medical  26. Place of Death (Check only one)										(y)							
o Be Completed	1 ☐ Yes 2 🗙 No	P 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other																
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To Be Completed	1 ☐ Yes 2 🗶 No	28a. Date of Inju (Month, Da	y Year) ury - At home,			163 201			28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office  City or Town, State)									
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			1 - For State Registrar	State of Maryl		artment of F			giene Reg. No.2	105	16	762
I	Physici		Decedent's Name (First, Middle, Las     Renard	Francis	Mı	ummaugh		2. Date of De. Month May	Day	2005	3. Time 10	
	/Medio Examir		4a. Facility Name (If not institution, give	street and number) ad		4b. City, Town, o Myer	r Location of Death	1	4c. Coun	ty of Death		<u> </u>
	Funeral Director		5. Social Security Number 6. Security Number 214–30–1677  Usual Residence of Decedent	X 7. Age (In)	yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Oct. 5	, 1932	9. Birthpl Count Mary	try)	or Foreign
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any njury or other treumatic event, Ir.e Marical Examilier must be retified at ance.	Completed by Funeral Director	10a. State 10b. County  Maryland Frederic  10e. Street and Number  9612 Harmony Road  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grace)	12. Was Decedent Ever Armed Forces?  1 X Yes 2 \( \subseteq \) N K Yes, Give Year or Dates: Council	orean onflict	1e  10f. Zip Code  21773  Was Decedent of H f Yes, specify Cubs 1□ Yes 2▼ No  dent's Usual Occup	Specify: ation during most of wor	pecify Yes or No o Rican, etc.)	10g. Citizen of United 14. Ra Bla Speci	State State ace - America ack, White, e	1 □ Ye.  try?  S  an Indian, atc.	City Limits s 2X No
Maryland 2121	uld be filed within Aental Hyglene. rked other than " tic event, Ire Mar	To Be Comple	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Leslie F. Mummau	College (1-4or 5+)	`life.	& Dye Ma	4)	ne (First, Middle,	United Postal Maiden Suma	Servi		
Baltimore, Mary	permit. Pages 1 and 2 she Department of Health and Importent: If item 27 is my any injury or other treums		19a. Informant's Name/Relationship (T.  Terri A. Guardin  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ 1  4 □ Donation 5 ☒ Other (Specify,  21. Signatur heral Service Licenses)	o/Daughter  Removal from State  Entombment	2131  Ob. Place of Disposer Gate of Mauso  Rose Rose Rose Rose Rose Rose Rose Rose	natory or other plac Heaven	Estates D May 2005	rive, Bi	cookevi 20c. Location Silver	11e, M City or Tov Sprin	ID 20 vm, State , Ma	Home/
8760,	Provided American and American and American and American and the brutal-transit	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of shock, or heart failure. List only of shock or heart failure. List only of shock or candidate cause or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a con	sequence of):	Card	g, such as cardiac	or respiratory ar	rest,		Approxima Interval Be Onset and	ate etween
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)				ate of deliver onth		Year
Records, P.	e faw requires that has been signed b je 2 should be deta	Completed by Ph	Part II. Other significant conditions co	/	resulting in the u	4	en in Part I.	23e. Did to 1	an 24b.	3 Proba	biy 4 □	Unknown available
Viital	ysicien: is certifica director,	To Be Com	25. Was case referred to medical examiner?	Hospital: 1 □ Inpatient 2	2 ☐ ER/Outpatien	t 3□ DOA Oth		perfor 1 ☐ Yes th (Check only of	med? 2000 2000 18)	prior to comdeath?  1 Yes 2  her (Specify)	<b>X</b> N∘	ause of
Division of	Attending or death. ector: After by the funer	Certification;	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  2 Natural 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year 28e. Place of Injury - A building, etc. (Sp	At home, farm, str		/ at <br Yes 2 □ No	28d. Describe h 28f. Location (S City or Tow	ow injury occu		Route Nun	nber,
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier (Check only one)  1 Certifying Phy 2 Medicel Exemple of Certifier Certifier Check only one)	sicien: To the best of my iner: On the basis of exam and manner stated.	knowledge, death	29c. License	oinion, death occu o number	rred at the time, o	date and place, 29d. Date signe	and due to t	ay, Year)	s)
<b>,</b>	H	1	30. Name and address of person who can Alan H. Rohrer,					rick, Ma	May 14 aryland			L
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra's Si		Coaste						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician May 14 2005 М Carolyn 0215 Gray Regester /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll County

If Under 1 Year | If Under 24 Hrs. |

Months | Days | Hours | Min. | Carroll County General Hospital Carroll 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Director <u>214 26 0463</u> May 3 1928 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. . other then "naturel", or tlems 23a or 28a-f show vent, the Medical Exeminar must be notified at 1 Yes 2 No Funeral Director Maryland Carroll Carroll County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 1004 Sharon Lane USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: à 3√ Widowed 4 □ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA Florist Regester Flowers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robb G Sills Minnie Lutelle Tharpe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan L. Hively 1004 Sharon Lane Westminster, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent: If it eny injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery May 19 2005 ' 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lassahn Funeral Home Inc

7/01 Relair Road Baltimore, Maryland 21236
shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Renal Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow signed by to Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🗆 N 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐mpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P this Director: After thi 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours To the Funerel tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 032822 UI IM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Conta Dr. Reinforton, Mel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For Stete Registrar	State of	Maryland / [		rtment			and M	lental Hy	giene	000	T NOTE OF THE PARTY OF THE PART	167	161
	Physici	an	1. Decedent's Name (First, Middle, L William		ichardson						2. Date of De Month May 1		005 Ye	ar	Time of L	рм Рм
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City,	Fown, or	Location o	of Death	ria y 1		County of D		5.50	PIVI
	- LAGIIII		St. Joseph Manor						ore C	•						
	Funeral Director		5. Social Security Number 6. 219-12-5411	Sex 1 M 2 □ F	7. Age (In yrs. last bii 80	thday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Big (Month, D) NOV	th (y Year)	9.	Birthplace Country) Mary 1	(State or	Foreign
	D		Usual Residence of Decedent								NOV.	70,13	27			
	Aarylau f show	ō	10a. State 10b. County 10c. City, Town or Location  Maryland N/A Raltimore City								10d. Inside City Limits 1 ☑ Yes 2 □ No					
	r 28a-	Director	Maryland N/A Baltimore City  10e. Street and Number 10f. Zip Code								10g. Citizen of What Country?					
	ath wit	ralD	911 W. Lake Avenue 21210										J.S.A.			
980	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be motified at	by Funeral	11. Marital Status  1							gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - A Black, W Specify:	merican la hite, etc. Whit		
5-0	72 ho "natur	eted	15. Decedent's (Specify only highest g		16a	Deced (Give )	ent's Usua kind of wor OO NOT us	l Occupa k done d	tion uring most	of worki	ng	16b. Ki	nd of Busine	ss/Industr	У	
21215-0036	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		oo notus Roman						Chur	ch		
	be filed tal Hygie d other i	O	17. Father's Name (First, Middle, La.						18. Mothe	r's Name	(First, Middle		Sumame)			
Maryland	should be nd Menta marked matic ev	To I	William	A.			rdson			ildr		).		elly		
Ma	nd 2 sl alth and 27 la r	1	19a. Informant's Name/Relationship St. Joseph Society S		t Priest		O N.				<i>Baltin</i>			e, 215 Coo		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic events.		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spec		20b. Place o camete Holly	f Dispos ry, crem Rede	sition (Name latory or ot EEMER	e of her place Cem	, etery	5/	19/05		cation - City 1 t i mor			
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Lig	ensee	De		Name and			U	altimon		Maryla Harfor		21214	
	Pnysician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that only one cause on ea	used the death. Do ch line.	not ente	the mode	of dying	, such as			rrest,		Inte	proximate erval Betwe set and De	
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a consequence	01): /cer of):	<u> </u>	1				-				
0	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. He for	er days be or as a consequence	of):					<u>-</u>					
8760,	icate be physici s the bu	dlcal		d												
.O. Box 6	ath certifi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bir	ome of pregnancy th 2  Fetal death int at time of death wn		Ectopic pre Other (spe	egnancy ecify)				2	23d. Date of Month	delivery Day	Ye	ear
Ω.	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions	contributing to dea	ath but not resulting i	n the un	derlying ca	use give	n in Part I.			obacco u Yes 2[	se contribute	e to the ca		
al Records,	The ate ha	Completed									24a. Was auto perio 1 \( \text{Yes}	osy ormed?	24b. Were prior death	to comple	tion of cau	
Vital	yaician: Th is certiticate director, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:				Othe			(Check only o				-	
o	ding Phya h. After this tuneral dii	n: To	27. Manner of Death	28a. Date of	patient 2 ER/Out	Itpatient Time of Injury		Bc. Injury Work	4671401	77777	ne 5 🗆 Resi 28d. Describe			(ipecify		
sior	Attending Phyaician: r death. ector; After this certitic by the tuneral director,	catio	1   Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	on	, Day (Sal)	пциту	М		es 2 🗆 N	No						
Division	i Sign	Certification;	4 Homicide determine	d 286. Place of buildin	of Injury - At home, fa g, etc. <i>(Specify)</i>						28f. Location ( City or To	wn, State,	)			91,
	To the Hospital or within 24 hours after To the Funeral Dir completely tilled in	edical	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ext	Physicien: To the laminer: On the bar aminer: And manner	pest of my knowledge sis of examination an er stated.	e, death nd/or inv	occurred a estigation,	t the tim in my op	e, date and inion, deat	d place, a	and due to the ad at the time,	cause(s) date and	and manner place, and o	as stated due to the	cause(s)	
•	To the within 2 To the complete	Me	29b. Signature and title of certifier	44/	us			License		09			e signed (Me	onth, Day,	Year)	
	le		30. Name and address of person wh	tonde 1	1. M. 7	(Туре, I	Print)	K Rd	Or Jus	ite.	200 7	ow:	on l	ide o	1/20	4
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature *										/			
DH	IMH 17 Rev 1/20	\$	MAY 1 8 2005 Seem & Sparks													

			State of Maryland / Depa  1 - State Requistrar  State of Maryland / Depa	rtment of Health and tificate of Death	Mental Hygien	2005	16765
	0		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		Alicia Maria Diaz Romero		Month Da		1330 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ath 40	c. County of Death	1
			Shady Grove Adventist Hospital	Rockville		Montgome	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	If Under 1 Year If Under 24 Hr Months Days Hours Mir	(Month, Day, Year	) COL	place (State or Foreign intry)
	Director		582-12-8358 81 Yrs.  Usuel Residence of Decedent		March 8, 19	124 Pue:	rto Rico
	yland how		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
	e Mar	ctor	Maryland Montgomery N.Po	tomac			1 ☐ Yes 2X No
	ith the	Directo	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Cou	intry?
	ath w	ral	17745 Stoneridge Drive	20878		ited Sta	
36	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show eny injury or other treumetic event, it e Madical Examination that he notified at once.	by Funeral	1 to Never Married 2 □ Married 1 □ Yes 2 to No	/as Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Pue ☑ Yes 2□ No Specify:Pue		14. Race - Ameri Black, White Specify: Whi	, etc.
Š	2 hou		15. Decedent's Education 16a. Decede	ent's Usual Occupation	16b. I	Kind of Business/I	ndustry
2	thin 7 e. en "r	Completed	(Specify only highest grade completed) (Give kife. D	rind of work done during most of w O NOT use retired)	orking		
2	ed wi ygien ygien yer th	Co		ws Analyst		eral Gov	ernment
and	be fill	Be	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maide.		
Ĕ	hould d Mer marke metic	L L	Rafael B. Diaz  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	Encarna  Address (Street and Number or F	cion Romero		n Code)
S	id 2 s Ith an 27 is i			Digging Road Mon	711	-	
ē,	s 1 ar f Hea item other		20a. Method of Disposition 20b. Place of Dispos		Date 20c 1	ocation - City or T	
Ë	Page nent o nt: If		Montgomery	17	May 3, 2005 Bet1	hesda M	arvland
Baltimore, Maryland 21215-0036	permit. Departm Importe eny inju			Name and Address of Facility Rockville, Inc. 30ckville, Marylan	bert A. Pum 0 West Mont	phrey Fungomery A	neral Home/ venue
	- 11 -		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Pnysician ·		Immediate Cause (Final disease or condition accure renal	failure		- 6	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):				13
	Examiner		Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):				days
	ed sit	iner	if any, leading to immediate Due to (or as a consequence of):				01.
	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last  C.  Due to (or as a consequence of):				days
8760	sician buris	dical E					
89	ifficate g phy as the	edic					
.O. Box	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as in	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of deliv Month	very Day Year
1	s that ned b e deta	by Pł	Part II. Other significant conditions contributing to death but not resulting in the unconditions	derlyîng cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ğ	w require been sig should b				1 ☐ Yes 2	No 3□Pro	bably 4 Unknown
ပ္သ	e law requ has been je 2 shoulk	Completed			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
Division of Vital Records,		Com			performed?	death?	
Ta Ta	Physicien: this certific	Be (	25. Was case referred to medical examiner?		eath (Check only one)		
<u></u>	hysic this call dire	ို	1 ☐ Yes No Hospital: 1 Inpatient 2 ☐ ER/Outpatient		Home 5 Residence		ify)
n C	ling P	lon:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred	
S	death death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be determined could not be determined.		28f. Location (Street a	nd Number or Rui	al Route Number
<u>&gt;</u>	after Direction by	Certification:	4 Homicide determined building, etc. (Specily)	ot, lactory, office	City or Town, Stat		ar riodio rvarrioor,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)	occurred at the time, date and place estigation, in my opinion, death occ	ce, and due to the cause(s curred at the time, date an	s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier	29c. License number		ate signed (Month,	
	2		Deceast Misty MD	DS9738	M	ay 15,	2005
_	YAI		30. Name and address of person who completed cause of death (Item 23a) (Type, PAICLAT. MISTY 9901 Mod.  31. Date filed (Month, Day, Year)  32. Registrar's Signature	rint) ical center	Drive Rock	ville, r	ND 20850
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	· Society			
Dri	Registr		MAY 1 8 2005 Heres 53	Figure			
$\neg \sqcap$	IMH 17 Rev 1/20	JU I	•				

			1 - For State Registrar	State of M	arylan			lealth and M	1ental Hyg	gien <b>e</b> 0 0 5	16766	
	,		Registrar  1. Decedent's Name (First, Middle	le last)		Cer	tificate of	Deam	2. Date of Dea	leg. No.	3. Time of Death	
	Physici		0 1		ocar	berg			Month	Day Yee	In and	
	/Medic Examin		4a. Facility Name (If not institution		USUI	Dord	4b. City, Town, or	r Location of Death	May	4c. County of De	9	
	LXamii		Northwest	Hospital			Randa	listown	1	BALTIMORE		
	Funeral		5. Social Security Number	6. Sex 7. Ag	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. E	Sirthplace (State or Foreign Country)		
	Director		219-05-0620 Usual Residence of Decedent	X	84	Yrs.			JUN.3, I	920	MASS.	
	yland sow		10a. State 10b. County	,	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits	
	a-fsh	tor	MD BAL	TIMORE		BALT	IMORE.				1 ☐ Yes 2 🎇 No	
	or 28	Director	10e. Street and Number				10f. Zip Code		1	log. Citizen of What	•	
	ath w	rail	2405 LIGHTF00					21209			USA	
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Decedent Armed Forces?  ned 1 \( \times \) Yes 2 \( \times \)	?	.S. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, hite, etc.	
2-003p	n 72 hours after death with the Maryland "natural", or lterna 23a or 28a-f show saftal Examinar must be notilled at	by	3 ☐ Widowed 4 🔀 Divorced	If Yes Give	110	1	∏Yes 21X No	Specify:		Specify:	WHITE	
ָה ה	72 ho natur	Completed	15. Deceden	nt's Education est grade completed)		16a. Deced	lent's Usual Occup	ation during most of work	ina	16b. Kind of Busines	ss/Industry	
7	within 72 ene. than "nai	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use retired	d)	,	OWN HOME		
7 0	filed w Hygie other th		17. Father's Name (First, Middle,	( act)		HOMEN	MANER	18. Mother's Name				
		To Be	LOUIS	2337		FREEI	OMAN	DORA	o (r ii ot, imiddio, i	maiden Somanie)	DOBRES	
ary	shou nd M mar	-	19a. Informant's Name/Relations	ship (Type, Print)					al Route Number	r, City or Town, State		
Ξ	and 2 alth a 127 is		HARRIET ROBBI	NS / DAUGHTE	R	2100	BURDOCK	ROAD - E	BALTIMOR	E, MD 212	09	
ore	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Permoval from State		lace of Dispo- emetery, cren	sition (Name of natory or other place		Date	20c. Location - City	or Town, State	
Saltimor	Pag tment tant:		'4 □Donation 5 □ Other (S		SH		ZION CEM.		7/2005	ROSEDAL		
e C	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic ev		21. Signature of Funeral Service	Licensee						ON & BROS	., INC. , MD 21208	
Ĺ			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that caused only one cause on each li	d the death	h. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between	
-	Pnysician		Immediate Cause (Final disease or condition	Multic	ر ا	phan	system	failur	es		Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or s	a conseq	uecce of):	. /				1	
E	0.80	ē	Securitially list conditions if any, leading to immediate	b. Nyoce Due to (or as	a consequence		arction	7			5 hours	
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Caracia	NEV.	arters	disea	(4)			>5 years	
Ď.	an an	Exa	resulting in death) Last	Due to (or as		uence of):	0,000	V.54			Syears	
8/PU	licate be executed physician and s the burial-transit	dicai		d								
٥	ding p	യ ഃ	IF FEMALE:	230 If you outcome	of process	inov.						
X D	wrequires that the death certif been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year	
j.	the d	nysic	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	9□ Unknown	t time or di	Jun 3 [	Outer (apacity)					
ر 7	The law requires that the ste has been signed by th page 2 should be detach	by PI	Part II. Other significant condition	ons contributing to death b	out not resu	ulting in the ur	derlying cause give	en in Part I.	23e. Did tot	bacco use contribute	to the cause of death?	
cords	en sig		Valvular heart	disease //	Type	IL die	abetes 1	nellitus	1 □ Ye	es 2 No 3 🗀	Probably 4 Unknown	
e C	law nas be	Completed	Chronie obstruc	tive pulmor	rary	disea	se cory	oulmonale	autops	sy prior t	autopsy findings available o completion of cause of	
<u> </u>	: The	Con		lure // Met	ab				perform 1 Tes 2	med <b>7</b> death′ 2 <b>Y</b> No 1 □ Ye	?	
VII	Physiclan: rthis certific ral director,	Be	25. Was case referred to medical examiner? 1  Yes 2 No				Othe	26. Place of Death				
ō	Phys	.: To	27. Manper of Death	28a. Date of Inju	iry	ER/Outpatient 28b. Time of	t 3□ DOA 28c. Injun Worl	4   Nursing no		ence 6 Other (Sp ow injury occurred	pecify)	
0	ath. r: Afte e fune	atior	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	ng (Month, Da	y Year)	Injury		k? Yes 2 □ No				
UNISION	er des recto by th	Certification;	3 Suicide 6 Could i	not be nined 28e. Place of Ini building, et	ury - At ho	ome, farm, stre	et, factory, office		28f. Location (St City or Town	treet and Number or i	Rural Route Number,	
5	ital or urs aft ral Di											
	To the Hospital or Attending Physician: The law within 24 bouts after death. To the Funeral Director: After this certificate has gompletely filled in by the funeral director, page 2.	Medicai	29a. Certifier 1 ☐ Certifyin (Check only one)	ng Physician: To the best Examiner: On the basis o and manner st	I examma	wledge, death tion and/or inv	occurred at the timestigation, in my of	ne, date and place, pinion, death occurr	and due to the cared at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)	
	within to the comp	Ž	29b. Signature and title of certifie	1			29c. License		2	9d. Date signed (Mo.	nth, Day, Year)	
	010		by socion	JMD				18462	/	May 15,	2005	
1	Ο,		30. Name and address of person  30 Ston		A	23a) (Type, I	tal Cor	iter Ro	andallet	nun Mar	Vland	
j	Sta	tę	31. Date filod (Month, Day, Year)	32. Registr	439	ture	proste	7	VICTORITOR	11/1/4/	714110	
	Registr	ar	M	AY 1 8 2006	May	45°	1					

# Places Type or Print in Plack Indelible Ink. Engure All Carios Ave Legible

3	For II 1 The 22 Sta	te of Man						•	-	noie.	1		
	1- Standard Item 23a, properties 1.	00.11,27	per m	Certifica	ate of	Death	.S	Re	g. No.	000	157	6	
in al	Decedent's Name (First, Middle, Last)     Blanche	pangler					2. Dat Moi Ma		Day	Year 2005	3. Time of De	ath M	
er	4a. Facility Name (If not institution, give street a	and number)		4b. Ci	ty, Town, o	r Location of I		у		ty of Death	, ATTA		
	Garrett County Hospi				kland				Garr	ett			
	5. Social Security Number 184–52–1695 6. Sex	A4	n yrs. last birth	rs. If Und	der 1 Year is Days	If Under 24 Hours	Min. 8. Date (Mo	of Birth oth, Day, -25,19	Year) 935	9. Birthp Coun Meyer	lace (State or F stry) scale, PA	oreigi	
ō	Usual Residence of Decedent  10a. State  10b. County  MD  Ga	arrett	Dc. City, Town	or Location		Acci	dent			1	0d. Inside City I		
Direct	10e. Street and Number 633 Negro Mountair			10f.	Zip Code	2152		10	g. Citizen of		itry?	_	
Be Completed by Funeral Director	1 Never Married 2 Married 1 If Y	as Decedent Eve ned Forces? Yes 2 No 'es, Give ar or Dates:	or in U.S.		cedent of H pecify Cuba 2 2 No	ispanic Origin an, Mexican, F Specify:	n? (Specify Ye Puerto Rican, e	s or No- etc.)		ace - Americ ack, White, ify: Wh			
ompleted	15. Decedent's Education (Specify only highest grade comp.  Elementary/Secondary (0-12)  8	nleted) Ilege (1-4or 5+)		Decedent's U (Give kind of life. DO NOT Homema	work done use retired	durina most o	of working	1	6b. Kind of I		dustry		
To Be C	17. Father's Name (First, Middle, Last)  Clarence Sel1			18. Mother's Name (First, Gertrude						ame)			
	19a. Informant's Name/Relationship (Type, Pri. Wilbur Spangler/Hus	•					or Rural Route Road A						
	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 ★Remova  4 □ Donation 5 □ Other (Specify)			Disposition (A), crematory of Cemete	r other plac		ay 18,		oc. Location				
	21. Signature of Poneral Service Licensee			22. Name and Address of Facility  Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave. Baltimore MD 21230						an .			
	23a. Part1. Enter the disease, of complications shock, or heart failure. List only one caus	se on each line.		ot enter the m	ode of dyin	g, such as ca	ardiac or respir				Approximate Interval Betwee Onset and Dea	en ith	
	resumno in deam)	hronic (			ulmon	ary Di	sease			-			
ner	cause: Enter Underlying	Due to (or as a co	onsequence of	f):									
ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of	f):		,							
Completed by Physician/Medic	in the past 12 months?	es, outcome of p Live birth 2 [ Pregnant at tim Unknown	Fetal death	3 DEctopio			-			ate of delive	ry Day Yea	r	
Y Ph	Part II. Other significant conditions contributing	ng to death but n	ot resulting in	the underlying	g cause giv	en in Part I.	230	e. Did toba	acco use cor	ntribute to th	e cause of deat	h?	
eted b	Atherosclerotic Cardi	ovascu1a	ar Dise	ease			_	1 🗆 Yes	s 2□No	3 🗌 Prob	ably 4 📉 Unk	nown	
Comple							-	a. Was an autopsy perform Yes 2	ed?	prior to cor death?	osy findings ava apletion of caus 2 No	ilable e of	
Be	25. Was case referred to medical examiner?	·			0.1		1 Death (Check	k only one	)				
ion: To	1 X Natural 5 ☐ Pending	1 ☐ Inpatient Date of Injury (Month, Day Ye	2XXER/Outp 28b. Ti ear) Inj	me of	28c. Injun Wor	y at k?			nce 6 00 v injury occu		")		
Certification; T	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e	. Place of Injury building, etc. (	- At home, farr Specify)	m, street, fact		Yes 2□No	28f. Loc	ation (Stre		ber or Rura	l Route Number	,	
ŭ							N'						

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

Division of Vital Records, P.O. Box 68760,

**Physician** /Medical Examiner

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*CXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

ANA

29c. License number OCME

29d. Date signed (Month, Day, Year)

May, 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

Medical

MAY 1 8 2005

RUBIO, MD

			For State	State of Mar		/ Departme	ent of Health	and Me	ental Hy	giene	005	167	68
			Registrar  1. Decedent's Name (First, Middle, Last	st)		00/11/10	ate of Beat		2. Date of De	Reg. No. ath	•	3. Time of	Death
	Physici		120	Scales		()	C		Month	Day	2005	430	AM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. C	ity, Town, or Locatio		rice	4c.	County of Death		
			Johns Hopkins	Bayview	Med	ical Civ	Balti		e		N/A		
	Funeral Director		5. Social Security Number 6. S 219-10-715 3	ex 7. Age (	78	t birthday) If Un Yrs. Mont		der 24 Hrs. s Min.	8. Date of Birt (Month, Da	th y, Year)	9. Birth Cou	place (State or intry) D.	r Foreign
	/land		10a. State 10b. County	1	10c. City, 1	Town or Location						10d. Inside Cit	ty Limits
	the Man 28a-f sh	ector	MD N/A			Baltimor	TE Zip Code			10a Cit	izen of What Cou	1 X Yes	2 🗆 No
	with 3s or		3910 Fait Avenue			101.	21224				JSA	itay:	
	death ms 2	hera	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was De	cedent of Hispanic (	Origin? (Spec	city Yes or No		14. Race - Amer		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any figury or other treumatic event, the Medical Eventh act rust be redified an once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:			pecify Cuban, Mexic		lican, etc.)		Black, White Specify: Wh	ite	
2-0	72 hc natur	Completed	15. Decedent's Ec	flucation de completed)	1	16a. Decedent's U	sual Occupation	ost of working	a	16b. Ki	ind of Business/Ir	ndustry	
21	vithin ne. han *	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)			work done during m Tuse retired)			D	-	_	
	filed v Hygie other t		10 years 17. Father's Name (First, Middle, Last)			Mail Ca		thada Nama	(First, Middle,		st Offic	e 	
Maryland	outd be f Mental H arked of atic ever	To Be	Leo J. Scales Sr.						Fiedler		Sumame)		
	1 and 2 sh Health and Iem 27 is m		19a. Informant's Name/Relationship (Cheryl L. Seebach	Daughte	r	87 Aven	way, Nott					o Code)	
Baltimore,	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition  1    Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specifi	memoval noni state		e of Disposition (interpretation) (inter		May	18,		ocation - City or T		
altii	mit. F Dartm Dortar Injur		21. Signature of Funeral Service Licen					2005	no Of F		ndalk,MD		
Ö	Depa Impo any ir		Knthony	Conne	lli	7110	and Address of Fac Funer Sollers I	rai Hon Point E	Road, I	Dunda	alk,MD.	21222	
	Pnysician		23a. Part1. Enter the disease or compands of the shock, or heart failure. List only Immediate Cause (Final disease or condition				node of dying, such					Approximate Interval Betwonset and D	eath
	/Medical		resulting in death)	Due to (or as a c								<u>05 m</u>	
8	Examiner	L	Sequentially list conditions,				farctio	n				2 mo	nths
	be sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to ( s a c	consequer	ice of):							
V	ate be executed hysician and the burial-transit	cal Examiner	that initiated events resulting in death) Last	c Due to (or as a c	consequen	ice of):							
9	be edician	alE		200 (0, 00 0)									
<b>2,09289</b>	tificate ng phys as the			d									
×o	leath certific attending p	√M(c	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy	у					23d. Date of deliv	erv	
Ö.	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 2 □ 4 □ Pregnant at tin 9 □ Unknown			c pregnancy (specify)				Month		ear
۵.	res that igned by be deta	y Ph	Part II. Other significant conditions of	ontributing to death but i	not resultir	ng in the underlyin	g cause given in Par	rt I.	23e. Did to	obacco u	se contribute to t	he cause of de	eath?
rds,	quires n sign ald be	q p	cellulitis, atr	ial fibrill	atric	on, aci	ote rena	<u>L</u>	1 🗆 Y	/es 2[	□No 3√Proi	pably 4 ⊟Ur	nknown
Record	s been si should	Completed	ingreatiency			3	,		24a. Was	an	24b. Were auto	opsy findings a	vailable
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ta	en: tifica tor, p	0	25. Was case referred to medical				26. Pla	ace of Death	(Check only o	2 No	1 🗌 Yes	280 No	
_	Physicien: this certifice ral director, p	To B	examiner? 1.☐ Yes 2.★No	Hospital: 1 Inpatient	2□ER	/Outpatient 3□	Other				6 ☐Other (Speci	fy)	
Division of Vital	fing After fune	ation:	27. Manner of eath  1 Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Y		b. Time of Injury M	28c. Injury at Work?	28	3d. Describe h			,	
Divis	I or Attendii after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	- At home (Specify)	e, farm, street, fac	tory, office	28	3f. Location (S City or Tow	Street and	d Number or Run )	al Route Numb	er,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	ledical C	29a. Certifier (Check only one)  (Check only one)	ysician: To the best of r niner: On the basis of ex and manner state	kamination	edge, death occurr and/or investigat	ed at the time, date ion, in my opinion, d	and place, ar leath occurred	nd due to the o	cause(s) date and	and manner as s place, and due t	stated. o the cause(s)	
	o the	Med	29b. Signature and title of certifier	wind manifer ofg(6)	-		29c. License numbe	ər		29d. Dat	e signed (Month,	Day, Year)	
)	⊢s⊢ö		Daugail Ho	cleu MD							-	-	
,	/		30. Name and address of person who	completed cause of deal	th (Item 23	Ba) (Type, Print)					7 17, 20	10	
	15		Abigail Holley L	LD Johns t	topk	ins Bay	RES-Q	lar i	3949	tas mo	re, Mn	212	24
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 8 2	32. Registrar's	Signature	fores	2						

State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Alphonzo Sembly 5 Joseph 12 2005 10:05p. <sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore N/A 1608 Northwick Road If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 219-10-0255 1 3cM 2 ☐ F MD Director 76 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itams 23s or 28s-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 77 is marked other than "natural", or Itams 23s or 28s-f show traumatic event, Its Mayles! Exame no trained at Baltimore 1XYes 2 No MD N/A Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21218 1608 Northwick Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced Year or Dates: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) AFL-CIO Longshoreman 12th N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Moore Maxine В. 2 Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21133 3616 Courtleigh Dr. Randallstown, MD Shelly Sembly-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Pk. 5/19/2005 Baltimore 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 21. Signature of Funeral Service Licensee M ady Q Warre Baltimore, MD 1101 E. North Avenue 21202 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on ear tipe. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performe page 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the within 24 hours after deati To the Funeral Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifie ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) mation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Moon, Day, Year) 29b. Signature and title of 2 30. Name and addr 31. Date filed (Month, Day, Year) 32 Begistrar's Signature State Registrar

**ORIGINAL** 

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			1 - For State Registrar		State of I	Maryland	-	artment rtificate			ind M	ental Hy	giene Reg. No.	0.0	5 1	6770	J
	Physic	ian	Decedent's Name (First, M.	iddle, Last)							i	2. Date of De Month 5	aath Day	Y	/ear	Time of Death	_
	/Medi	cal	Carrie			Crorey			nith			5	11	2005		5:07a ^	4
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	Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs. la	st birthday)	If Under	1 Year	If Under 2		8. Date of Bir	rth		Birthplace (	State or Foreig	חנ
	Director		216-52-0576		]M 2 <b>4</b> €]F	56	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 9 19	1948	3	S.C.		
	and		Usual Residence of Deceder 10a. State 10b. Co			10c. City.	Town or Lo	cation							10d. In	side City Limits	S
	the Marylar 28e-f show	jo	MD	N/A			altimo									¶Yes 2 □ No	
	r 28e	rec	10e. Street and Number					10f. Zip	Code				10g. Citiz	en of Wh	at Country?		
	h with	a	615 Melvil	e Ave	enue			2	21218	3				USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene importent: If item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at page.	by Funeral Director	11. Maritał Status 1 □ Never Married 2 □ 3 □ Widowed 4 □ Divo	Married	12. Was Decede Armed Force 1 ☐ Yes 2{ If Yes, Give	s? <mark>X</mark> No	1	Was Deced if Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	ecify Yes or No Rican, etc.)	İ		American Inc White, etc.	dian,	
215-0036	ture!	ed b		dent's Edu	Year or Date	s:	16a, Dece	dent's Usua	I Occupa	ition			16b Kin	d of Busin	Black ness/Industry		
215	within 72 ene. than "ne	Completed	(Specify only h.	ghest grade	College (1-4d	or 54)	(Give	kind of wor DO NOT us	k done d	lurina most	of worki	ng	TOD. PUR	G 01 D 2011	nood maastry		
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yla	should Ind Meni	2			Crorey						cene			Rice			
Maryland	12 sh h and 7 is n traun		19a. Informant's Name/Related Thomas B. Sm:	, , ,				-				Altimor			•	)	
	1 and Healt Iem 2 other		20a. Method of Disposition		isbaria	20b. Pla	ace of Dispo					ate			21218 ity or Town, S	tate	
Ω	ages ant of nt: # ii y or o		1 🛣 Burial 2 □ Cremat 1 4 □ Donation 5 □ Other		emoval from Sta		metery, crei Crisor				5/18	/2005		ings	Mills		
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rds	w require been sig should b	edk										1 🗀	Yes 2	No 3	Probably	4 Unknown	1
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Division	t or Attending after death. Director: After In by the fune	fica	3 ☐ Suicide 6 ☐ Co	uld not be	28e. Place of	Injury - At hon	ne, farm, str	_				28f. Location (	Street and	Number	or Rural Rout	e Number,	
ā	in the	Certification:	4  Homicide ue	Onnada	building,	etc. (Specify)						City or To	wn, State)				
	To the Hospitet or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical (	29a. Certifier (Check only one) Cert	fying Phys cal Exami	sician: To the be ner: On the basis and manner	s of examination	rledge, death on and/or in	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) a date and p	nd mann place, and	er as stated. d due to the c	ause(s)	
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			1- State of Maryland / Department / Department / Departmen	artment of Health and Martificate of Death		iene eg. No. 2 A A S	A may upo a
			Decedent's Name (First, Middle, Last)		2. Date of Deat	th Callet d	3. Time of Death
	Physici /Medio		Bernard Duley Spicer, S	r.	Month May 14,	Day Year	0030am M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			Calvert Memorial Hospital	Prince Frederick		Calvert	
	Funeral		5. Social Security Number  220-07-0723  6. Sex  7. Age (In yrs. last birthday)  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Co	nplace (State or Foreign untry)
	Director		220-07-0723 TW 207 86 Vrs.		Feb. 4,	1919  Mary	land
	yland		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	e-f	ctor	Maryland Prince George's U	pper Marlboro			1 ☐ Yes 2 ☐ No
	or 28	Directo	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	untry?
	s 23a		9705 Rosaryville Road	20772		U.S.A	
	items nern	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Never Married 2 Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never M	Was Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
336	urs af	þ	3V Widowed 4 Divorced If Ves, Give 1940 — 1	1 ☐ Yes 2 🛣 No Specify:		Specify: W	hite
ğ	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural; or items 23a or 28e-f ehow imatic event, it a Medical Examiner is ust be incitifed at	Completed	15. Decedent's Education 1945	dent's Usual Occupation		16b. Kind of Business/l	ndustry
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2	filed wi Hygien other th		/tn Firen	man - Civil Servic		AAFB Fire D	epartment
ğ	d la b	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name			
ž	should ind Men marke	မ	Eppa H. Spicer  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin		B. Duley		
Maryland 21215-0036	d 2 stranger			ng Address (Street and Number or Rure ) Duley Station Ro			
<u>6</u>	permit. Pages 1 and 2 should D. portment of Health and Men In portant: If item 27 te marke at y njury or other traumatic ore.			sition (Name of natory or other place) May 2		20c. Location - City or 1	
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	permit. Pag D pertment In portant: In pinty o		21. Signature of Fundral Service Lyens e 22	. Name and Address of Facility Le	e Funera		С.
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П	8		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	lascular Distave			
	aaiiiiiici	<u>.</u>	Sequentially list conditions, b. Due to lor as a second regress of the	Pascular History			
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٥	ng ph as th	Med	IF FEMALE:				
X R R	leath certific attending p I for use as	Physician/Me	23h Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of deliv	
	the at	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year
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ds,	signe d be	d by	The second secon	designing cause given in a art i.		s 2□No 3□Pro	
cord	law requir as been si 2 should	Completed			24a. Was ar	24h Mara aut	anny findings available
T T	The lav	duc			autopsy	prior to co	opsy findings available ompletion of cause of
VITAI	ilcian: Th certificate rector, pag	a)	25. Was case referred to medical	26. Place of Death		Yes 1 □ Yes	2-5 No
	Physician: this certific al director,	O B	examiner? 1 ☐ Yes 2 No Hospital: Inpatient 2 ☐ ER/Outpatient	Other		nce 6 Other (Speci	(v)
		n: T	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe ho		.,,,
20	endir eath. or: Al	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
UNISION	or Attendation of Attendation of Director; in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Str. City or Town,	eet and Number or Rui , State)	al Route Number,
_	pitai ours a erai C		29a. Certifier 17 Certifying Physicien: To the best of my knowledge death				
	e Hos 24 hc e Fun etely	ledical	29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, death (Check only one)  Certifying Physicien: To the best of my knowledge, death (Check only one)  Medicel Exeminer: On the basis of examination and/or invane)  and manner stated.	estigation, in my opinion, death occurre	and due to the ca ed at the time, da	use(s) and manner as a te and place, and due t	stated. to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the funeral Director.	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
	111		Dand ( Trado m	047610	1	May 15 ;	100
1	417	7	30. Name and address of person who completed cause of death (Item 23a) (Type, F				
	1		David J. Tardio, MD 110 Hospital R	Road Suite 310 Pri	nce Fred	lerick MD 20	0678
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature			, 4	
	- riegisti	ell	MAY 1 8 2005				

DHMH 17 Rev 1/2001

ORIGINAL

DEWARN	SPENCE	ΞR	1- State of Magistrar	Marylan		artment of <i>rtificate of</i>	Health and M <i>Death</i>		giene Reg. No. 0	15	15	172
	Physici /Medi		Decedent's Name (First, Middle, Last)  Darw	arn D.	Spen	cer		2. Date of De Month MAY 8		Year	3. Time o	of Death
	Examir		4a. Facility Name (If not institution, give street and number UNIVERSITY HOSPITAL	or)			or Location of Death		4c. County of			
i	Funeral Director		216-98-9345 <sup>1</sup> ™ <sup>2</sup> □ F	Age (In yrs. 1	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da Oct 15	h y, Year) , 1977	9. Birthpla Count	ace (State iny) Md.	or Foreign
	/land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	/, Town or Lo	ocation				10	d. Inside C	City Limits
	e Man Ba-f sh	ctor	Md. N/A			E	Baltimore				1 🖰 Yes	s 2□No
	h with th	al Dire	10e. Street and Number 605 North Monroe Street			10f. Zip Code	21217		10g. Citizen of W	hat Count U.S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked ofther than "netural; or Items 23a or 28a-1 show any injury or other traumatic event, the Marical Examinar must be notified at once.	by Funeral Director	11. Marital Status  12. Was Deceder Armed Force 1 X Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced	s? <b>₫</b> No	1	Was Decedent of If Yes, specify Cult	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- America c, White, e		
00-6	2 hour		15. Decedent's Education	i: 	16a. Dece	dent's Usual Occu	pation		16b. Kind of Bus			
Maryland 21215-0036	d within 7 giene. er than "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4o	r 5+)	(Give life.		during most of work. ed) ed Worker	ing			rporatio	nc
pur	be file tal Hy od othe event,	Be	17. Father's Name (First, Middle, Last)  Henry Spencer				18. Mother's Name		Maiden Sumame	)		
aryle	should nd Mer marke imatic	4	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Stree	t and Number or Rura			State. Zin (	Code)	
, X	and 2 ealth a n 27 ls		Cynthia Reese Mother		60	5 North Moi	nroe Street Bal				,000,	
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition  1 🔀 Burial 2 □ Cremation 3 □ Removal from Stat  4 □ Donation 5 □ Other (Specify)		emetery, crei	sition (Name of natory or other pla Zion Cemet	ace)	05/18/05	20c. Location - C	City or Tow Sdowne		
Balt	permit. Departr Importe any inju		21. Signature of Europa al Service Licensee		22	Name and Addr	ess of Facility Brothers Funer utaw Place Ba	al Service F	PA 121217			
	Frrysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)  Due to (or a	line.	3 06	er the mode of dy	ing, such as cardiac of	or respiratory an	rest,	1	Approximat Interval Bet Onset and I	tween
68760,	s be executed sician and burial-transit	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequ								
.O. Box 687	t the death certificate by the attending phy: ached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	2 Fetal	death 3	Ectopic pregnanc	у		23d. Date Mont			Year
rds, F	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to death	but not resu	Iting in the u	nderlying cause gr	ven in Part I.	1	bacco use contrib es 2. █No 3			
Division of Vital Records, P.O.	The law re cate has been page 2 sho	Completed						24a. Was a autops perfor	sy pri med? de	or to comp ath?	sy findings a	available ause of
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 □ No Hospital: 1 Yanga			O#	26. Place of Death			117	-	
jοι	ding Phys h. After this funeral di	n: To	27. Manner of Death 28a. Date of In	iury	P/Outpatien 28b. Time of	t 3□ DOA 28c. Inju Wo	4   Nursing Hor		ence 6 Other			
Sior	tendin leath. Ior: Ali the fur	ertification:	2 Accident investigation 2/11/03	5	8:51 F	M 1	Yes 2 No	SUBTECT		HOT		
Divi	al or At s after o	Sertifi	determined 286. Place of II	etc. (Specify)	)	eet, factory, office		City or Tow	treet and Number n, State) ∨okt H & St			Authore
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the besit and manner sand mann	t of my know of examinati	dedge death	Occurred at the ti	me date and place a	and due to the c	ause(s) and mans	nor ac class	od	nD)
	vithir To the	M	29b. Signature and title of certifier			29c. Licens			9d. Date signed (		ıy, Year)	
	A		30. Name and address of person who completed cause of	death (Item	23a) (Tyne				MAY 9, 2	2003		
<u>.                                    </u>	/		ANA RUBIO, MO	)	1	11 Penn	Street Ba	altimore	e, Maryla	and 2	1201	
	Stat Registra	- 4	31. Date filed (Month, DMAY) 1 8 200532. Reg	trar's Signati	110	psile						

			For State Registrar	Stat	e of Ma	ryland / Dep <i>Ce</i>	artment of l		nd Mer		iene <sub>g. No.</sub> 20	05	16773
P	hysicia	an	1. Decedent's Name (First, Midd	le, Last)	Poho	rta E. Sco	\t+			Date of Deat Month	Day	Yeer 5	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution	on airo street an		ita L. Scc	4b. City, Town,	or Location of	Death	IV	lay 8, 200 4c. County		
	xamin	er				o Inc	4D. City, TOWII,		Baltimor	re	40. 000111		/A
			5. Social Security Number	seph Riche		(In yrs. last birthday	If Under 1 Year		4 Hrs.   8.	Date of Birth			
	ineral rector		213-20-0161	1 ☐ M 2 🔀	, -	79 Yrs.	Months Days	Hours	Min.	(Month, Day, Aug 19	Year)	Cou	place (State or Foreign ntry)  Md.
-			Usual Residence of Decedent							7109 10	1020		
yian	how		10a. State 10b. Count	/		10c. City, Town or L	ocation						10d. Inside City Limits
M S	a-f.	cto	Md.	N/A			E	Baltimore					1⊠Yes 2⊡No
Ť.	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of		•
# #	23a		1208 Cherry Hill Ro					2122				U.S.	
ar de	tems	Funerai	11. Marital Status	Arme	Decedent E ed Forces?		Was Decedent of If Yes, specify Cul	Hispanic Origi ban, Mexican,	in? (Specify Puerto Rica	/ Yes or No- an, etc.)		e - Ameri ck, White	can Indian, , etc.
s afte	o.	by F	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Ye	Yes 2 ∏ No s, Give ror Dates:	•	1 ☐ Yes 2 🗓 No	Specify:			Specif	y:	Black
Pod	tural	ed b	^	nt's Education	or Dates.	16a, Dece	dent's Usual Occu	pation		- 1	16b. Kind of B	usiness/lr	ndustry
in 72	fed in	Completed	(Specify only high	est grade comple		(Give	kind of work done DO NOT use retire	during most	of working				
with jene.	that the	mo	Elementary/Secondary (0-12)	Colle	ege (1-4or 5+	,	Но	memaker				Own F	lome
Hyg	othe	Be C	17. Father's Name (First, Middle	, Last)				18. Mother	's Name (Fi	irst, Middle, I	Maiden Sumar	ne)	
ld be	rked Ic e	To B	Re	bert Turne	er					Eth	el Dorsey		
Last y trailed & L.C. I.C. COOO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	item 27 ie marked other than "natural", or items 23a or 28a-f ehow other traumatic event. I're Medical Exarti er musi ke natifiked at		19a. Informant's Name/Relation	ship (Type, Print	1)	19b. Mail	ing Address (Stree	t and Number	or Rural Ro	oute Number	City or Town,	State, Zij	p Code)
and 2 ealth a	n 27 l er tra		Shirley L. Smith Da	ughter		The state of the s	523 Plainfield	Avenue					
of He	Important: If item 27 le any injury or other trai once.		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal	from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ace)	Date	130	20c. Location	- City or T	own, State
Pages . Pages tment of l	ant: I ury o		'4 □Donation 5 □ Other (			N	etro Cremato	ory	05/	/12/05	Ca	atonsvil	le, Md.
permit. Departn	Import any inj once.		21. Signature of Funeral Service	Licensee	2 +	$-\alpha \leq D^{-2}$	2. Name and Addr			2000 (2000)			
<b>1</b> & &	E & 8		Ceal	1/2 6	SU	P.XI	1300 E	Brothers F Lutaw Plac	uneral : ce Baltin	service nore. Mai	yland 21	217	
Dhye	sician		23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final	t only one cause	that caused to on each line	death. Do not en	ter the mode of dy	ing, such as c	ardiac or re	spiratory arre	est,	nt.	Approximate Interval Between Onset and Death
	dical		disease or condition resulting in death)	a	e to (or as a	consequence of):	1 acci	00,0				- 14	LWEEKS
Exa	niner				,								
		Jer	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	D. DI	ie to (or as a	consequence of):							
ate be executed	ransi	Examiner	that initiated events	c									
<b>5</b> 8 .	ian a		resulting in death) Last	Du	e to (or as a	consequence of):							
ate be ex	physician and the burial-transit	dicai		d									
	D SE	Mec	IF FEMALE:	80-16		4					-1		
ath o	been signed by the attendin should be detached for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 1		Fetal death 3	Ectopic pregnani	ру				te of deliventh	ery Day Year
. 8	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Pregnant at t Unknown	me or death 5	Other (specify)						
hat th	d by detac		Part II. Other significant condit	ions contributing	to death but	not resulting in the	underlying cause g	ven in Part I.		23e. Did tot	acco use con	tribute to t	the cause of death?
i se i	signe d be	1 by	Huger-Jen	sion	,	<b>3</b>	,,,			1 □ Ye	s 2 No	3 ☐ Prol	bably 4 Dunknown
	hould	etec	119/50 1011			-			_	04-146	-   045	Mara and	
e aw	has t	Completed								24a. Was a autops perforr	n 240. y ned?	prior to co death?	opsy findings available ompletion of cause of
Ē	cate , pag	S						·		1 ☐ Yes 2	19 No		2 12 No
ician:	ector	Be	25. Was case referred to medic examiner?	Hospital:			_ 0	her		heck only on			/
Phys	this aldir	2	1 ☐ Yes 2 ☑ No 27. Manper of Death		1 Inpatien Date of Injury		III 3 DOX	4 🗆 Nurs		5 Reside	nce 6 Oth		ty) respice
ding.	After	ion	t Vatural 5 ☐ Pend		(Month, Day	Year) Injury	W	ork? ∃Yes 2.⊟N		. 200020	,,		
ttend	the the	ical	3 ☐ Suicide 6 ☐ Could	not bo	Place of Injur	v - At home farm st				Location (St	reet and Numb	er or Run	al Route Number,
or A effer	Direc	Certification;	4 Homicide	nined 200.	building, etc.	y - At home, farm, si (Specify)	root, labiory, onloc			City or Town	, State)		
spital	filled		29a. Certifier 1 Certify	ng Physician: T	To the best of	my knowledge, dea	th occurred at the	ime, date and	place, and	due to the ca	ause(s) and ma	anner as s	stated.
o the Hospital or Attending Physician: The law requires that the death certific within 24 hours effer death.	e Fur letely	edical		i Examiner: On		examination and/or in							
To th within	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of pertific	Ore			29c. Licer	se number		2	9d. Date signe	dj (Month,	Day, Year)
	N		Holmt	Music	MO		200	56211			5/8/	05	
. 1	71		30. Name and address of person	who completed	cause of de	ath (Item 23a) (Type	Print)		1 0	11	1 - 1		
4			JOHN F. 3	IRWIN	M.D.	3001	S. Hano	ver St	F E	altin	nove, 1	0 2	11225
1 (2)	. Sta	te	31. Date filed (Month, Day, Yea	AY 1 8 20	32. Registra	S Signature	Souli	,					

			1- State of Ma Registrar State of Ma	ryland / Depa 43 5-18-0	artment of He	ealth and M Death	ental Hyg	iene) (	05	16774		
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  SORRELL LESTE	Lester	Sorrel1		2. Date of Deat Month	h Day ノス	Year 0.5	3. Time of Death		
	Examir	ner	4a. Facility Name (If not institution, give street and number)  BON SECOURS HOS  5. Social Security Number 6. Sex 7. Age	PITAL (In yrs. last birthday)	4b. City, Town, or L	ocation of Death Baltin If Under 24 Hrs.			ity of Death			
	Funeral Director		213-60-5423 1 2 F V Age	53 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, May 1,		9. Birthpi Count	ace (State or Foreign ry) Va.		
	Manyland -f show lied at	tor		10c. City, Town or Lo		timore		_	10	0d. Inside City Limits 1 X Yes 2 No		
	with the	Director	10e. Street and Number 633 North Aisquith Street		10f. Zip Code	21202	10	0g. Citizen o	f What Count	•		
36	4 within 72 hours after death with the Maryland Jione. r than "natural", or Items 23a or 28a-f show The Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 Yes, 2 No	)	Was Decedent of His f Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto i	ocify Yes or No- Rican, etc.)		ace - America ack, White, e	an Indian,		
Maryland 21215-0036	within 72 ane. than "nat	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)		ng		Business/Ind			
and 2	e file othe vent,	e	12 17. Father's Name (First, Middle, Last) Lester Tolliver		<u>_</u>	18. Mother's Name		Maiden Suma				
Maryi	2 sh end ls m	안	19a. Informant's Name/Relationship (Type, Print) Wanda Brown		ng Address (Street arr		l Route Number,	City or Tow		Code)		
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren	755	D		20c. Location	- City or Tov			
Balti	permit. Page Depertment of Important: If any Injury or once.		21. Signature of Funeral Service Licens		. Name and Address	of Facility		ce PA Md 21217				
	Pnysician, /Medical Examiner	ner	Sequentially list conditions, b.	consequence of):	on the mode of dying,  on the first of the f	such as cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death		
68760,	ficate be executed physician and is the burial-transit	edical Examiner	that initiated events c.	conseque/cl of):	Voice	CIS						
.O. Box	that the death certifit ed by the ettending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver	y Day Year		
rds, P	sign d be	by	Part II. Other significant conditions contributing to death but	not resulting in the ur	iderlying cause given	in Part I.	23e. Did tob	_ /		a cause of death?		
al Records,	The law ate has b page 2 sl	Completed					24a. Was an autopsy perform		prior to com death?	sy findings available pletion of cause of		
1 Tyes 2 No 1 Tyes 2 No 1 Tyes 2 No 1 Tyes 2 No 1 Tyes 2 No 1 Tyes 2 No 2 Tyes									ther (Specify)			
Divis	Direction	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	/ - At home, farm, stre (Specify)	eet, factory, office	2	8f. Location (Str. City or Town,		ber or Rural	Route Number,		
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	29a. Certifier (Check only one)  1 Sertifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and/or inv	estigation, in my opin	nion, death occurre	d at the time, da	te and place	, and due to	the cause(s)		
)	or Tour	-	29b. Signature and title of certifier Peols		29c. License r	76 4 A	p   29	d. Date sign	ed (Month, D	2005		
1	27		821 N Eulaw St	th (Item 23a) (Type, I	int 3/2	-Bel	hinora	A	1021	201.		
	Sta Registr		31. Date filed (Month, Day Year), MAY 1 8 2005	s Signature	back					,		

ADH RAYMOND SMOOT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05-3373 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 19:06 RAYMOND KEITH SMOOT MAY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner John HOPKINS HOG BANTMONE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1-31-1953 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 213-64-092 1☐M 2□F MARYLAND Yrs. Director 52 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exant or must be notified at MD. BALTIMORE RANDALLSTOWN 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 OJIBWAY RD. 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 🖾 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) -12-WELDING CONSTRUCTION -0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES E. SMOOT BERTHA JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2813 GRESHAM WAY WINDSOR MILL, MARYLAND 21244 KENYA KELLY (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposit permit. Pages 1
Department of H
Important: If itel
any injury or ott Cremation 3 Removal from State 1 Burial 2 KING MEMORIAL PARK 5-21-2005 ` 4 ☐ Donation BALTIMORE, MARYLAND 5 Other (Specify) ral Service License JONATHAN HIBN R2. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ih /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-translt Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 X Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Ŋ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 2 this 28d. Describe how injury occurred pocared pri sonovi molusding 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death After Certification Division 5 Pending investigation 1 Natural after death. 18:22P 5/14/05 Hercation with prison quards 2 Accident in by the 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) Control Banking 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after determined 4 Homicide JAIL 300 East Madison St. Baltimone ML within 24 hours a

To the Funeral is
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated. 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) OCME May 16, 2005 oss of person who completed gause of death (Item 23a) (Type, Print)

111 Penn Street 30. Name and addre

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

Baltimore, Maryland 21201

Physic	an	Decedent's Name (First, Middle, Last)	10f,12&19b PER FH Marian B. Tilghma	n h m n in	2. Date of Death Month Da	3. Time of Dea
/Medi Examii		4a. Facility Name (If not institution, give si	treet and number)	4b. City, Town, or Location of E	may 1	4 2085 0136 County of Death
Examil	er Ser	Northwest Ho	- + 11 Carl	Randallston	in Maryland	Baltimore
Funeral Director		214-26-101	M 2 F (In yrs. last birthda	Months Days Hours	Hrs. 8. Date of Birth (Month, Day, Year	9. Birthplace (State or For Country)  MICHIGAA
how		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location	<i>v</i> .	10d. Inside City Lin
r 28a-f ehow	Director	MARYLAND N/	A		IHORE C	/ T / 1 1 Yes 2
2.24	ai Dir	per CY	SCT. ROAD	10f. Zip Code 2120	10g. C	lizen of What Country?
items 23s	Funerai	11. Marital Status	Was Decedent Ever in U.S. 1:     Armed Forces?	3. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- tuerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
el', or i	by	1 ☐ Never Married 2 💆 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🗖 No Specify:	·	Specify: BIACV
natur	Completed	15. Decedent's Education (Specify only highest grade	ation 16a. Dec	cedent's Usual Occupation we kind of work done during most of the DO NOT use retired)	working 16b. F	Kind of Business/Industry
giene. or than the Mg	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	Ui:	S. POSTAL LIBRA
at the	Bec	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, Maider	2. / 5011
nd Menta marked matic ev	ပ္	JAMES  19a. Informant's Name/Relationship (Typ)	N, KJR	OWN CAR	OLINE G.	WILLERTON
alth ar 27 io r trau		GRETCHENT CURR	e, Print) 19b. Ma V (DALIGHTER) (O	lling Add Elaw Ool and Number o	Rural Route Number, City	or Town, State, Zip Code)
<u> </u>		20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □ Re		position (Name of rematory or other place)		ocation - City or Town, State
rtmen rtant: njury		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	GARRIC	SON FOREST OF	3.0	INGS MILLS, M.
lmpo eny ii		wethich	N. William	JOSEPH H.		TO, MD. 21211
ysician Medical aminer		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.  AHLIO SCIEV  Due to (or as a consequence of):	1		Approximate Interval Between Onset and Deat
hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
physic s the bi	dicai	d.				
igned by the attending pl be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
67 2-1	þ	Part II. Other significant conditions contr	ibuting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death
	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause death?  1 Yes 2 No
s certif	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital: 1  Inpatient 2 ER/Outpatie	04	Death (Check only one)	
in. : After this certificate has e funeral director, page 2		27. Manner of Death  1	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	g Home 5 Residence 28d. Describe how injur	
ector by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Locetion (Street an City or Town, State	d Number or Rural Route Number, )
To the Funeral Dir	Medical	29a. Certifier 1 Certifying Physic (Check only one)	r: On the best of my knowledge, dear r: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and plantestigation, in my opinion, death of	ace, and due to the cause(s) ccurred at the time, date and	and manner as stated. place, and due to the cause(s)
9 9	ž	29b. Signature and title of certifier	1	29c. License number		e signed (Month, Day, Year)
To the complet						
To the		30; Name and address of person who com	4000	D00368	19 M	ay 14, 2005

DHMH 17 Rev 1/2001

		1 - For State Registrer		f Marylar	•	artmer rtificat			and M		Reg.	00	05	167
Physicia /Medic Examin	al	Decedent's Name (First, Middle, L.     Edwin J. Ticha     Aa. Facility Name (If not institution, gi		nber)	<del></del> .	4b. City,	Town, or	Location o	of Death	2. Date of D Month May	12,	2005 4c. County	Year of Death	3. Time of Dec 9:50 a
	eı	1800 Petula Cour	t	7. Age (In yrs.	last birthday)			st Hi	11	8 Date of F		Harf	ord	place (State or Fo
Funeral Director			1 □ M 2 □ F	92	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, I Sept.	Oay, Ye	1912	Ma	ryland
Maryland a-f show	ctor	10a. State 10b. County  Md. Harf	ord	10c. Ci	ty, Town or Lo		est	Hill					1	0d. Inside City L 1 ☐ Yes 2
h with the 23a or 28 st be no	Funeral Director	10e. Street and Number 1800 Petula Cour	t			10f. Zip	Code	210	)50			Citizen of V	Vhat Cou	ntry?
ours after deal	by Funer	11. Marital Status  1 Never Married 2 Married 3 Never Married 4 Divorced	12. Was Dece Armed For 1 🕍 es If Yes, Giv Year or Da	2 □ No e	1	Was Dece If Yes, spe 1  Yes		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto l	ocify Yes or N Rican, etc.)	lo-		k, White,	ean Indian, etc. ite
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Infinoratinent of Health and Mental Hygiene. Infinoratine if the m 27 Is marked other than "neturel", or Items 23s or 28s-f show eny injury or other treumetic event, the Medical Exercities must be a citifical angone.	Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12 years 17. Father's Name (First, Middle, Las	rade completed) College (1	-4or 5+)		dent's Usu kind of wo DO NOT u neeri	ork done d se retired	luring most )			ga (	Kind of Bus and (BGE)	ele	
ould be fill Mental Hy arked oth	To Be	Thomas Ticha								(First, Middle Voji			e)	
and 2 sho lath and 127 ls m		19a. Informant's Name/Relationship Elizabeth Goldt		ghter						est H				Code)
Dermit. Pages 1 a Department of Hes Important: If item any injury or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special Control Co	□Removal from S	State	Place of Dispo cemetery, crer 21 Air	natory or o	ther plac			/2005		Location - Sel Ai		
permit. Departm Importa eny inju		21. Signature of Funeral Service Lice			22	Name ar Schin	nd Addres nunek	s of Facility	ral	Home o	of B	sel Ai	r, I	
Physician /Medical Examiner physician and physician and the prival-transit the prival-transit physician and physic	al Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Due to (	ach line.  Act House as a consecution as a consecution or as a consecution or as a consecution as a consecut	Quence of): Hickney quence of):	er the mod	de of dying	g, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between Onset and Deat Hoyrs.
The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	aldeath 3□	Ectopic p						23d. Dat	e of delive	ery Day Year
juires that n signed by	by	Part II. Other significant conditions OSteomthrits		eath but not res	sulting in the u	ndertying o	ause give	en in Part I.			tobacc	o use contr	ibute to th	ne cause of death
(0	Completed	Stephthrites Fallene to to	hon								s an opsy formed	? 5	rior to co leath?	psy findings avai mpletion of cause 2 No
Physicien: T this certificateral director, pa	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 1	npatient 2	EB/Outpatien	it 3□ DC	Othe		of Death	(Check only		6 □Oth	ar /Snaciń	
	- 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date o (Montal		28b. Time of Injury		28c. Injury Work		2	28d. Describe				,,
el or Attending s after death. el Director: Afte ed in by the fune	Certification:	3 Suicide 6 Could not lead to determine determined	1 28e. Place	of Injury - At h	ome, farm, str	eet, factor	, office		2	8f. Location City or To	(Street оwп, St	and Numb ate)	er or Rura	l Route Number,
To the Hospitel or within 24 hours afte To the Funerel Director completely filled in h	edical	29a. Certifying P (Check only one)  Certifying P 2 Medical Exe	hysician: To the miner: On the ba and mann	isis of examina	owledge, death ation and/or in	n occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, a	and due to the	e cause e, date a	o(s) and ma and place, a	nner as si and due to	ated. the cause(s)
To II To II comp	W	29b. Signature and title of certifier				290	License	number	3		29d. I	Date signed	Month,	Day, Year)
2		30. Name and address of person who Stephen Smaldor								. 2101	4	1.4	- J	
Sta Registr		31. Date filed (Month, Day, Year)	₽. Re	egistrar's Signa	ature /			-		•				

			1 - For State Registrar	State		aryland / Dep		t of H	ealth a	and M	fental Hyg	iene og. No: 0	05	16778
	Physic /Medi	cal	1. Decedent's Name (First, Midd Helen		M	Thom					2. Date of Deat Month May 10	2005	Year	3. Time of Death 12:27A M
	Exami		4a. Facility Name (If not institution Clinton Nursin 5. Social Security Number		. Ce	enter e (In yrs. last birthday,		Clir	Location of the Location of th		8. Date of Birth	Prin		orge's
	Funeral Director		579-34-3763 Usual Residence of Decedent	1 M 2 TF	75	Yrs.	Months	Days	Hours	Min.	Oct. 14	,1929	Wash	place (State or Foreign ntry) ington, DC
	he Marylan :8e-f ehow	ector	Maryland 207			10c. City, Town or L Suitla							1	0d. Inside City Limits 1 ☐ Yes 2 🃉 No
	eath with the 23s or 2	by Funeral Director	3205 Ryan Dri				10f. Zip	2074					J.S.A.	
036	ours after d al', or Iterr Exeminer	by Fun	11. Marital Status  1 □ Never Married 2 □ Ma. 3 ☒ Widowed 4 □ Divorce	If You C	orces? 2∏ Ne	ło	was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:	gin? (Spi n, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ ack, White, ify: W	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Iteme 23a or 28e-f show event, the Modified Everning raust be notified at	Completed	15. Decede (Specify only highe Elementary/Secondary (0-12) Unknown	nt's Education est grade completed,	1-4or 5	(Give	dent's Usua kind of wo DO NOT us	rk done d se retired,	uring mos	t of work	ing	6b. Kind of I		dustry
Maryland 2	be d a la la la la la la la la la la la la l	To Be Co	17. Father's Name (First, Middle Benjamin Fr		nckr		les (	Terk	18. Mothe		e (First, Middle, M Alice Hi	laiden Suma	ail me)	
	d 2 in ar th ar 7 is trau	-	19a. Informant's Name/Relation Diane Hoste		Frie	end 5523	Kepp	oler	Road		al Route Number, ple Hill			
Baltimore,	permit. Pages 1 an Depertment of Heal Importent: If item 2 any injury or other QDCE.		20a. Method of Disposition  1  Burial 2  Tremation  4  Donation 5  Other (3	Specify)	State		tory Name an	d Addres	s of Facilit	May y Le	11,2005 e Funera	1 Home	n, Ma	ryland
	Physician /Medical Examiner		23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	_ a (1)	20	the death. Do not enter.	er the mod	e of dying			or respiratory arre	st,		Approximate Interval Between Orlet and Death
gven,	n certificate be executed anding physician and use as the burial-transit	ilcal Examiner	Sequentially list conditions, and second course. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	_ : (	a consequence of):	ti	Ha	~	2				10honh
O. BOX 68	death e atte d for	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth :	2 Fetal death 3	Ectopic pre						ate of delive	ry Day Year
Hecords, P	The law requires that the site has been signed by the page 2 should be detached.	eted by P	Part II. Other significant conditi	ons contributing to d	eath bu	t not resulting in the u	nderlying ca	ause give	n in Part I.		23e. Did toba	. /		e cause of death?
ущаі жес	sician: The law certificate has b irector, page 2 s	Completed									24a. Was an autopsy perform	/	prior to cor death?	osy findings available inpletion of cause of 2 No
5	s certi	To Be	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☐ No	Hoepital:	Innation	nt 2 ER/Outpatien	3 □ DO.	Othe	. /		(Check only one			
DIVISION OF	to the Hospital or Attending Physician: within 24 hours after death: or the Funerel Director: After this certifics completely filled in by the funeral director.	Certification; T	27. Mar er of Death  1 Natural 5 Pendir 2 Accident investi	28a. Date (Mon gation	-	28b. Time of		Bc. Injury Work	at	2	me 5 ☐ Resider 28d. Describe how			9
	pitel or Att ours after d erel Direct filled in by i	I Certific	3 Suicide 6 Could 4 Homicide determ  29a. Certifier 1 Certifyir	nined 28e. Place buildi	ng, etc.	ry - At home, farm, str. (Specify)	,				28f. Location (Stre City or Town,	State)		,
	o the Hospitel within 24 hours a 1 o the Funerel [ completely filled	Medical	(Check only 2 Medical one)	Examiner: On the b	asis or	f my knowledge, death examination and/or in ed.	occurred a estigation,	at the time in my opi	e, date and nion, deat	i place, a h occurre	and due to the cau ed at the time, dat	ise(s) and m e and place,	anner as sta and due to	ated. the cause(s)
^		2	29b. Signature and little of partifie	m2	)		29ç.	License 2	number	35	29	Date signs	ed (Month, L	Day, Year)
1	Sta	to	30. Name and address of person  31. Date filed (Month, Day, Year)	a M.D. 7700	01	ath (Item 23a) (Type,	Print)	mire	#101	(0)	linton, 1	lary la	na 20	735
DHM	Registr H 17 Rev 1/20	ar	MAY 1	0.000-	les		osett.							
						ORIGIN	AL.							

			Please	State of Mary						-	
			1 - For State	State of Mary		rtificate of l		i wentai m	Reg. Ne	11116	16770
			Registrar  1. Decedent's Name (First, Middle, Last	t)				2. Date of D	eath		3. Time of Death
	Physici		Edward Scott Ta					May 14	Da 20	y Yeer 005	1:40P M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea			. County of Dea	
			13438 Bissel Lar	ie		Potomac			N	<u>lontgome</u>	
	Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hi Hours Mi	n. (Month, D	ay, Year	9. Bir	thplace (State or Foreign puntry)
H	Director		558-04-1446	201	44 Yrs.			Aug.	9, 1	960   Co.	lorado
	ow .		10a. State 10b. County	10	c. City, Town or Lo	ocation					10d. Inside City Limits
	Mary Firsh	tor	Maryland Montgome	erv	Potomac						1 ☐ Yes 2 💢 No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	ountry?
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "naturel", or items 23a or 28a-f show afte event, I'm Medical Exercitre court be codified at		13438 Bissel Lane	ž		20854				ed Stat	
	tems	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? In, Mexican, Pue	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Ame Black, Whit	
36	rs afte	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:			Specify:	nite
Maryland 21215-0036	2 hou	edk	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation		16b. I	Kind of Business	
212	hin 72	Completed	(Specify only highest grad	de completed)  College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of w f)	vorking			
2	od wit	Com		5+	Seni	or Vice I	Presiden	nt	Ae	ero Spac	e
nd	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	e, Maide	n Sumame)	
Z	ould Men Parke	ပ	Emmett R. Taft					ee Ann Bo			
Nar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examination at any injury or other traumatic event, if a Medical Examination at any injury.		19a. Informant's Name/Relationship (7			ng Address <i>(Street a</i> 88 Bissel					Zip Code) 0854
	1 and Healt om 2		Kimberly A. Taft,		Oh Place of Disno	sition /Name of		Date Date		ocation - City or	
Baltimore,	ages ant of t: If it		1 Burial 2 Cremation 3 :	D	cemetery, crei	matory or other plac	وعند				
	artme ortan injur		21. Signature of Funeral Service Licen	y see	Cremator 27	ry ium, Inc. 2. Name and Addres		005 Robert A.	Bet Pur	nesda. nphrev F	Maryland Tuneral Home
ä	Depa Impo any ii		1 Kurit	Down, M	ronona R	ockville,	Inc. 3	00 West	Mont	gomery	Avenue
1	3		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only		death. Do not ent	ter the mode of dyin	g, such as cardi	iac or respiratory		702	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ingio Caro					Onset and Death Months
	/Medical		resulting in death)	Due to (or as a co		ingro dare	zmoma				110111111
U	Examiner		Sequentially list conditions,	b							
- 32	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a co	паециенсе оі).						
	xecut and al-trar	xan	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	ensequence of):						
760,	icate be executed physician and s the burial-transit	calE		d							
89				U							
Вох	the death certifica y the attending ph ched for use as th	M/U	230. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy				23d. Date of de	livery
о. П	ed fo	sicie	in the past 12 months?	4 Pregnant at time		Other (specify)				Month	Day Year
<u>Р</u>		Physician/Med	9 Unknown				. 5	on- Did			
	86 28	by	Part II. Other significant conditions co	ontributing to death but no	ot resulting in the u	nderlying cause give	en in Paπ I.		Yes 2	_	the cause of death?
Records,	w require been signal	Completed				·		-			
Rec	has be 2 s	mpi			<u> </u>			24a. Wa auto	s an opsy formad?	24b. Were at prior to death?	itopsy findings available completion of cause of
_		e Co	25. Was case referred to medical					1 ☐ Yes	2 N		2 No
Viital	Physicien: this certifica ral director, I	o Be	eyaminer?	Hospital:	2 ER/Outpatier	nt 3 DOA Othe	OF.	eath <i>(Check only</i> Home 5X Res		a Clour /0	-16.1
	- a = B	-	27. Manner of Death	28a. Date of Injury (Month, Day Ye		f 28c. Injury	at	28d. Describe			City)
0	Attending or death. ector: After by the fune	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		nar) Injury	M 1 🗆	k? Yes 2 □ No				
Division	I or Attend after death Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str	reet, factory, office	2.5	28f. Location City or To	(Street a	nd Number or Ri	ural Route Number,
	urs afte	Ce	•								
	To the Hospital or A within 24 hours after or To the Funeral Directompletely filled in by	dical	29a. Certifier 1  Certifying Phy (Check only one) 2  Medical Exam	vsician: To the best of my	y knowledge, deat amination and/or in	h occurred at the tim vestigation, in my op	ne, date and pla pinion, death oc	ce, and due to the curred at the time	cause(s	s) and manner as nd place, and due	s stated. to the cause(s)
	To the To the To the Complet	NA NA	29b. Signature and title of certifier	and manner stated.		29c. License				ate signed (Mont	
	- 3 - 3/	0	V (21: 1.		_	D42				16, 200	
î	0		30. Name and address of person, we come	completed cause of death	(Item 23a) (Type		474		nay	109 200	
1	'C		Chitra Rajagopal			D14144	Drive,	#327, 01	ney,	Maryla	nd 20832
	Sta			32. Registrare							
	Registr	ar	Si AV	1 8 2000	and white the						

DHMH 17 Rev 1/2001

			Amend it	State <sup>201</sup> Marylar	Td fbe8843	The alth and	Mental Hygier	1e	
			1 - State Registrar			te of Death	Reg. N	0000	16790
	Physicia		1. Decedent's Name (First, Middle, Last)	LEE	WRI	GHT	2. Date of Death Month	Day Year 7 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. Ci	y, Town, or Location of Deat		c. County of Deat	h
			5. Social Security Number 6. Sex	TOSPITA 7. Age (In yrs.		er 1 Year If Under 24 Hrs.	HORE.  8. Date of Birth	9. Birt	hplace (State or Foreign
	Funeral Director		218-74-0266	M 20F 4	4 Yrs. Month	s Days Hours Min.	Month, Day, Yea	ar) Co	EORGIA
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Location	2			10d. Inside City Limits
	e Man Sa-f sh	ctor	MARYLAND N.	IA		ALTIMOR		-1	1 Yes 2 □ No
	with the Maryland a or 28a-f show Lee notified at	Funeral Directo	10e. Street and Number	eneu hr	101.	Zip Code 212		Citizen of What Co	untry?
	death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer		14. Race - Ame Black, White	nican Indian,
0000	72 hours after death with the Marylar "natural", or flams 23a or 28a-f show digal Examinar must be inclifted at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		2 ☑ No Specify:	, , ,	Specify: 12	1 ANV
2-0	72 hours "natural", idical Exa		15. Decedent's Educ (Specify only highest grade	cation	16a. Decedent's U	sual Occupation work done during most of wo.	rking 16b.	Kind of Business/	Industry
Z	within ene. then the here	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DISTRIB	work done during most of wo.	/	SINAI	HOSPITAL
N	filed v t Hygie othar i	0	17. Father's Name (First, Middle, Last)	. 1	DISTRIB		me (First, Middle, Maid		14001 11772
yıar	ould be Menta arked atic ev	To B	ERNEST		MES	Boe	BBIE C		RIGHT
Mar	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty) BOBBIE WRIGHT	OB, Print)  MOTHER	19b. Mailing Address	ess (Street and Number or Ri WABAS IF		in the second	(ip Code) (a, M.D. 21215
ore,	es 1 ar of Hea fitam r other		20a. Method of Disposition  1	20b.	Place of Disposition (I		Date 20c.	Location - City or Owings M	Town State Md.
	Pag ment ent: I ury o		'4 □ Donation 5 □ Other (Specify)	*	NG MEN	PARK 5-	25-05-6		ON, MARYLAND
Бапп	permit. Departming permit. Importe any inju		21. Signature of Funeral Service License	Na Allin	10 22. Name		NOWN JI NAVE, B.	K, FUNE ALTO, M	RAL HOME
	10.6		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the dea					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ne na	/ faile	•			Onset and Death  2 weeks
	/Medical Examiner			Due to (or as a consec					6 yers
/	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classase or injury)	Due to (or as a consec	quence of):				
į,	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):				
3/60	ate he	icai		l					
ž X	eath certifice attending ph I for use as t	/Med	IF FEMALE: 2	3c. If yes, outcome of pregn	nancy			23d. Date of del	ivery
. Box	death ie atter ed for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown			· · · · · · · · · · · · · · · · · · ·	Month	Day Year
J.	hat the de od by the a detached		9 Unknown  Part II. Other significant conditions con		sulting in the underlyin	g cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ecords,	The law requires that the ste has been signed by thoses 2 should be detached.	d by		chribs, C	-	Lagils	1 ☐ Yes	2 □ NO 3 □ Pr	obably 4 🗆 Unknown
eco	law rec as bee 2 shor	Completed					24a. Was an autopsy	prior to o	stopsy findings available completion of cause of
r							performed 1 ☐ Yes 2 ☐		2 No
Vital	ysiciar s certif directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	fospital: 1 Inpatient 2	ER/Outpatient 3	- Other	ath (Check only one)  Home 5 Residence	6 □Other (Spe	cify)
n of	ing Ph Viter th uneral	on: T	27. Manner of Death  1 Autural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		
Division	Attand death ctor: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h		1 ☐ Yes 2 ☐ No tory, office	28f. Location (Street	and Number or Ri	ural Route Number,
2	tal or / rs after el Dire	Certi	4  Homicide determined	building, etc. (Spec	ify)		City or Town, St	170)	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical				ed at the time, date and plac- ion, in my opinion, death occ			
	To the within To the comple	Me	29b. Signature and title of certifier	7		29c. License number	ļ.	Date signed (Monti	
	1.1		I four h	NO		D40136	5	5/17/05	
	311		30. Name and address of person who co	mpleted cause of death (Ite	om 23a) (Type, Print)	D40136 + , Su, te 30	Belloni	e, 121	1201
	Sta	ate	31. Date filed (Month, Day, Year)	320Registrar's Sign	nature				

	3310	1	Please Type or P			•	•
int.	on Witt	OC:	State of I State Amend Item 1&Unpend I	Maryland / Depart	ment of Health and France G84	d Mental Hygie 1 <b>4 6-17-0</b> 5 t	ne as nns 16701
			Hegistrar  1. Decedent's Name (First, Middle, Last)	25d, Certin	ilcate of Death	2. Date of Death	3. Time of Death
	Physici /Medi		LINTON ANTON		FOCK JR.		2005 Year 0005A. M
	Examir	ner	4a. Facility Name (If not institution, give street and numb. Saint Agnes Hospital	<i>)r)</i> 41	b. City, Town, or Location of E Baltimore	eath	4c. County of Death
g	Funeral Director		5. Social Security Number 6. Sex 7.		f Under 1 Year If Under 24 Ionths Days Hours I		9. Birthplace (State or Foreign Country) 1984 PENNSLY VANIA
7)	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Locati	ion		10d. Inside City Limits
	e Marylan la-f show	ctor	MARYLAND NIA		BALTIM	ORE CI	Ty 12 Yes 2 No
	within 72 hours after deeth with the Maryland ane. then "naturel", or Items 23e or 28e-1 show the Medical Evenifier must be notified at	al Director	10e. Street and Number 422 BURBANK	COURT	10f. Zip Code	10g.	Citiken of What Country?
	Items	Funeral	11. Marital Status  12. Was Decede Armed Force  1 Never Married 2 Married  1 Yes 2	s? If Ye	s Decedent of Hispanic Origin es, specify Cuban, Mexican, P		14. Race - American Indian, Black, White, etc.
036	ours after o rel', or Iten	by	3 Widowed 4 Divorced Year or Date	1 🗆	Yes 2 No Specify:		Specify: BLACK
21215-0036	in 72 h n "natu fealica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind	t's Usual Occupation d of work done during most of NOT use retired)	working 16t	b. Kind of Business/Industry
212	7 5 -	Comp	Elementary/Secondary (0-12) College (1-40	(5+)	PASHIER		WALMART
Maryland	ges 1 and 2 should be filed t of Health and Mental Hyg If item 27 Is marked other or other treumatic event,	Be	17. Father's Name (First, Middle, Last)  LINTON ANTONIO	WITTOCK	- 0	Name (First, Middle, Mai	den Sumame)
aryl	2 should be and Menta Is marked eumatic ev	T <sub>O</sub>	19a, Informant's Name/Relationship (Type, Print)		Address (Street and Number o	RNETT Rural Route Number, C.	ity or Town, State, Zip Code)
	1 and 2 Health em 27 I		BURNETT MC FADDEN (MO 20a. Method of Disposition	THER) 422 20b. Place of Disposition	BURBANK	CT. BAL	TO. MD. 21227
mor	Pages ent of I nt: If its		1 Burial 2 □ Cremation 3 □ Removal from Sta  '4 □ Donation 5 □ Other (Specify)	te cemetery, cremato	CEMETERY 5.		C. Location - City or Town, State
3altimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licensee	10 22. N	ame and Address of Frility	BROWNU	R. FUNERAL HOME
	₫ O E 9 0		23a. Part1. Enter the disease, or complications that cause	KIMMO 2	140 N. FULT	ONAVE, D	ALTO, MD, 21217 Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition resulting in death)  Cardiac artery	line.	associated wit curing during		Interval Between
	Examiner	J.	Sequentially list conditions, b. Due to (or.	as a consequence of):			
	executed n and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	15 d 001100qd01100 01).			
60,	be executed cian and burial-transit		regulting in death\ Leat	as a consequence of):			
687		edica	d				
P.O. Box	ath ce ttendii or use	Physician/Medica		2 Fetal death 3 Ect at time of death 5 Ott	topic pregnancy her (specify)		23d. Date of delivery Month Day Year
	uires that the de signed by the a d be detached f	by	Part II. Other significant conditions contributing to death	but not resulting in the under	rlying cause given in Part I.		co use contribute to the cause of death?
COL	law requir as been si 2 should l	olete				24a. Was an	24b. Were autopsy findings available
Division of Vital Records,	The lay	Completed		-	-	autopsy performed	prior to completion of cause of death?
Vita	Attending Physicien: r death. sctor: After this certifica by the funeral director, I	Be	25. Was case referred to medical examiner?  1 ঐYes 2 ☐ No  Hospital: 1 ☐ Inpa		Othor	Death (Check only one)	
lof	ig Phy ter this neral d	n; To	1 A Yes 2 No 1 No 1 No Inpa  27. Manner of Death 1 Natural 5 Pending (Month, I		28c. Injury at Work?	g Home 5 Residence 28d. Describe how in	
isioi	Attendir death. ctor: Af y the fu	icatic	2 Accident investigation 3 Suicide 6 Could not be	10:40	M 1 ☐ Yes 2 X No	Subject as	
Div	s after at Direct at Direct at Direct at the by	Certification;	4X Homicide determined 28e. Place of building, Street	njury - At home, farm, street, etc. (Specify)	factory, office	City or Town, Si	rand Number or Rural Route Number, tate) rear of 456 Bigley
	To the Hospital or Attending Physicien: The within E Arnous after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	of examination and/or investi	curred at the time, date and pl igation, in my opinion, death o	ace and due to the cause	e/s) and manner as stated
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
			· Closeur		OCME	May	13, 2005

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. ARA WELLE MARCHINE (Type, Print)

111 Penn Street Baltimore, Maryland 21201

2005

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** May 15 2005  $A^{M}$ John George Willard 1:10 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Dulaney Valley Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1□ M 2□ F Days Hours Months Director 214 22 2053 December 9 1927 Philadelphia, Usual Residence of Decedent 10b. County 10c. City, Town or Location r then "neturel", or Items 23a or 28e-f show the Medical Examination ust be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 5147 Terrace Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Ith and Mental Hygiene. 27 is marked other then 'treumetic event, Ite Men Elementary/Secondary (0-12) College (1-4or 5+) N/A Supply Officer State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental George Dewey Willard Marie Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If Item 27 is 7 or other tre Jacqueline G Willard 5147 Terrace Drive Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Importent: If any injury or Gardens of Faith May 20 2005 \* 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Sona ure of Funeral Se 22. Name and Address of Facility
Lassahn Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) GLIOBLASTOMA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Physician/Medlcai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page certificate 2 No 1 🗌 Yes 2 **X** No Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6X1Other (Specify) HOSPICE Certification: To 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred Division After 1 X Natural 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29b. Signature and atte of certifier 29d. Date signed (Month, Day, Year) 29c. License number 5/16/03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State MAY 1 8 2007 Keen & forth Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State

Registrar

32. Restrar's Signature

8

			For State Registrar	State o	f Maryland / De	epartment of F Certificate of			iene g. No.200	5 16784	
	Physici		Doris H Wallace Month Day Year May 11 2005 10							ear 3. Time of Death 10:00a M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death						4c. County of Death		
1	Examin	eı	, , , , , , , , , , , , , , , , , , , ,	407 Morris Hil		,		en Burnie	Ar	Anne Arundel	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birtho	(ay) If Under 1 Year	If Under 24 I		Your) 9	Birthplace (State or Foreign Country)	
	Director		216-32-1529	1 □ M 2√2 F	76 Yr	Months Days	Hours N	Min. (Month, Day, Aug 17,		Md.	
	pu ,		Usual Residence of Decedent		10c. City, Town o					101 1-11-01-11-11-	
	shov	ž	10a. State 10b. Coun		Toc. City, Town C		en Burnie			10d. Inside City Limits 1 X Yes 2 No	
	28e-1	Director	Md. A	Anne Arundel			on Durine	14/	Og. Citizen of Wh		
	with the	급	407 Morris Hill Ave	nue		10f. Zip Code	21061		•	U.S.A.	
	leath	Funeral	11, Marital Status	12. Was Dec	edent Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba		? (Specify Yes or No-		American Indian,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. tiem 27 is marked other than "naturat", or Items 23a or 28e-f show other traumatic event, If a Madical Examinating the notified at		1 ☐ Never Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Divorce	If Yes Gir	2 No ve No	If Yes, specify Cuba		uerto Rican, etc.)	Black, Specify:	White, etc. Black	
9	2 hou	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kir					16b. Kind of Busin	ness/Industry		
215	within 72 ene. than "n	ple	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)				State of Maryland				
21	filed with Hygiene other the ont, If a	NO.	12	,	,	(	Clerk		Otate	- Or Wild yield	
nd	be file	Be	17. Father's Name (First, Middle			:	18. Mother's	Name (First, Middle, M	<sup>raiden Sumame)</sup> Ora Jane		
<u>Y</u> a	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ira M.	၉		obert H. Carter							
Maryland 21215-0036	12 st h and 7 is n traun		19a. Informant's Name/Relation		196. N	,		r Rural Route Number, len Burnie, Md.		ate, ZIP Code)	
	ges 1 and of Health If item 27 or other tr		20a. Method of Disposition	Sparid	20b. Place of D	isposition (Name of		-	20c. Location - Ci	ty or Town, State	
no			1 X Burial 2 Cremation 4 Donation 5 Other		State	crematory or other plac		05/16/05		ridge, Md.	
Baltimore,			21. Signature of Fuperat Service		wead	lowridge Memor 22. Name and Addre		00770700	2211		
B	permit. Departr Imports any inju		1 200	mel !	~	Estep B	Brothers Fu	uneral Service	ndand 2121	7	
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between								
			Immediate Cause (Final disease or condition	FA	0 57AC					Onset and Death	
			resulting in death)	a. Due to	(or as a consequence f)	1.		atto		1000	
			Sequentially list conditions,	b	2001		500	10			
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- Due to	(or as a conseque ve of)	:					
	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c	(or as a consequence of)	:					
8760,	ate be ex hysician the buria	dical		d							
9	tificate ig phys as the	ledi						- th			
Вох	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No	1 ☐ Live t 4 ☐ Pregr	tcome of pregnancy birth 2  Fetal death nant at time of death	3 Ectopic pregnancy 5 Other (specify)	4		23d. Date of Month		
P.0	that the de ned by the a detached t	hys	9 🗆 Unknown	own							
	ires tha sign <b>e</b> d I d be det	by	Part II. Other significant cond	itions contributing to d	eath but not resulting in the	ne underlying cause giv	ven in Part I.	23e. Did tob		ute to the cause of death?  ☐ Probably 4 ☐Unknown	
Š	w requir been si should	etec	0000		1 (	0	,	24a. Was ar	24b Wa	re autopsy findings available	
Records,	nysician: The law nis certificate has I I director, page 2 s	Completed	per-pha	h ALI	Comme	Acrtic	Avec	autopsy perform	prio	or to completion of cause of ath?  Yes 2 No	
Vital	stan: artifica ctor,	Bec	25. Was case referred to medie examiner?		20 70 1		26. Place of	Death (Check only one	9)		
of V	Physician: this certific ral director,	၉	1 ☐ Yes 2 ☑ No		Inpatient 2 ER/Outp		4 🗀 (4012))	ng Home 5 # eside			
М	ling P	inol iii	27. Mann Death 1 atural 5 ☐ Pen	unig	of Injury 28b. Tin th, Day Year) Inju	iry Wor	yat rk? Yes 2∐No	28d. Describe ho	w injury occurred		
Division	l or Attending after death. Director: After I in by the fune.	lcat	3 Suicide 6 □ Cou		of Injury - At home, farm		165 2 140	28f. Location (Str.	reet and Number	or Rural Route Number,	
<u>&gt;</u>	al or A after I Direction by	Certification:	4 - Homicide dete	ermined 200. Flace build	ing, etc. (Specify)	, strast, rastory, smoo		City or Town			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical C		al Examiner: On the b	e best of my knowledge, of examination and/oner stated.						
	To the within 2 To the	Me	29b. Signature and title of certi	fier		29c. Licens	se number	29	9d. Date signed (	Month, Day, Year)	
	O.A.		7	ard	ms	D	317	44	5/1	3/2004	
	O		30. e and dress of perso	Penniv	-ston A	pe, Print)	3	1/time	o, mi	21226	
	Sta Registr		31. Date filed (Month, Day, Yea	AY 1 8 2009	strar's Signature	> Sprile	,				

			For State Registrar	State of Maryl	and / Depa	artment of H	lealth and N	lental Hygi	•	6785	
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death	
н	Physici		CHARLES L	EROY WIL	LIAMS			05 15	Day Year 2005	2:50 A M	
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	r Location of Death	1	4c. County of Deat		
			2409 GUILFORD AVE	NUE		BALTI	IMORE		N/A	A	
	Funeral Director		219-20-1338	7. Age (In 66	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 11/27/1	9. Birth Co.	nplace (State or Foreign untry) MD	
	and *		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits	
	faryli et el	ō			•					1 XYes 2 No	
	death with the Maryland ms 23a or 28a-f ehow rinust be nutified at	Director	MD N/A		BALTI	10f. Zip Code		100	2. Citizen of What Co	Λ	
	should be filed within 72 hours after death with the Marylan to Mental Hygiene.  Marked other then "neture!; or Items 23a or 28a-f ehow marked other then "neture!; or Items 23a or 28a-f ehow metic event, the Macing Examinar must be notified at		2409 GUILFORD AV	ENHE.		21218	}		USA	,-	
	Jeath	Funeral		12. Was Decedent Ever	in U.S. 13.	Was Decedent of H		ecify Yes or No-	14. Race - Ame	rican Indian,	
0	r Her	Fun	1 Never Married 2 Married	Armed Forces? 1 ☑XYes 2 ☐ No				Rican, etc.)	Black, White		
<u></u>	ours a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:195	8-64	1 ☐ Yes 2 ☐ No	Specify:		Specify: BLA	ACK	
<u>က</u>	within 72 hours after ene. then "neture!, or Ite he Medical Examine	eted	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occup	ation during most of work	cina 16	b. Kind of Business/	ndustry	
2	ithin 19.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired					
2	lygier her th			5±	ATTOR	NEY AT LA			LAW	-	
בַ	be fit ital H id oth	Be	17. Father's Name (First, Middle, Last)	TITITAMC				e (First, Middle, Ma	,		
<u>\{ a</u>	ould Men Parke	ပို		WILLIAMS			NELLIE	V. KING			
Maryland 21215-0036	nd 2 sulth ar		19a. Informant's Name/Relationship (Ty BEVERLY HARSTAD/S						City or Town, State, 2 K, MD 217(		
Baltimore,	es 1 a of Hea fitem r othe		20a. Method of Disposition	20	b. Place of Dispo	osition (Name of matory or other place	(e)	Date 20	c. Location - City or	Town, State	
Ĕ	permit. Pages Department of Importent: If it any injury or conce.		1 X Burial 2 □ Cremation 3 □ F  14 □ Donation 5 □ Other (Specify)			MEM. PK.	5/20	/05 B	ALTIMORE,	MD	
alt	mit. partn porte y inju		21. Signature of Funeral Service License	96 1						NS F.H., INC	
m	89 <b>E 2</b> 9		James 9	, Worken	1	701 LAURE	ENS ST.,	BALTO., M	D 21217		
	Physician /Medical Examiner		23a. Parte Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the recause on each line.  Due to (or as a cor		/ Sabernu .	ig, such as cardiac		t,	Approximate Interval Between Onset and Death	
	ficate be executed physician and is the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor							
.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pri 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3[	□Ectopic pregnancy □ Other (specify)	,		23d. Date of deli Month	very Day Year	
rds, P.	w requires that been signed I should be det	by	Part II. Other significant conditions con	ntributing to death but no	t resulting in the u	inderlying cause giv	en in Part I.		cco use contribute to	A	
Records,	The law re ate has bee page 2 sho	Completed						24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of	
Vital	10	O	25. Was case referred to medical				26. Place of Dear	th (Check only one)			
	Physicien: this certificanal director,	S B	examiner? 1 ☐ Yes 2 XNo	fospital: 1   Inpatient	2 ER/Outpatie	nt 3 DOA Oth	O.F.		ce 6 □Other (Spec	cify)	
vision	ling After fune	tion: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury				injury occurred		
	# 0 D >	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, st	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	ledicai (	29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my ner: On the basis of examination manner stated.	knowledge, deal mination and/or in	th occurred at the tin	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)	
1	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	dino	· ·	29c. Licens	e number 9838	290	5/17/200	n, Day, Year)	
je	TY	Y	30. Name and address of person who co	empleted cause of death	(Item 23a) (Type,	Print Bestga	se Rd.	Annap	5/17/200 01/3, Wd	7	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar S	Signature	porte	)				

			1 = For State Registrar	State of Maryla	nd / Dep		Health and M	Mental Hy	giene	16786	
	· ·		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death	
Ų.	Physici /Medi		Stewart Homer Welsh					Month May	15 2005 2005	2:50 A M	
1	Examir		4a. Facility Name (If not institution, give	4b. City, Town, or Location of Death			4c. County of Death	4c. County of Death			
			Carroll Hospital Center Westminster						Carrol1		
	Funeral Director		5. Social Security Number  215-34-5154  Usual Residence of Decedent	x 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month Da Dec 6,	y, Year) 9. Birth Y, Year) Mary	place (State or Foreign intry) Land	
	/iend	Director	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits	
	sa-f sh		Maryland Carroll	Woo	odbine					1 ☐ Yes 2X No	
	with ti		10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?	
	99th 1	era	7040 Woodbine Rd.	12. Was Decedent Ever in I	16 12	21797	Ulana da Calada (O.		Inited State		
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show with jnjury or other traumatic avent, if a Medical Evarulina inval be notified at ance.	by Fun	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ⊠Yes 2 □ No If Yes, Give 1963	_	was Decement or If Yes, specify Cub 1 ☐ Yes 2 ♣ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Decity Yes or No- Di Rican, etc.)			
21215-0036	"natura	Completed by Funeral	15. Decedent's Edu (Specify only highest grad	reation (de completed)	16a. Dece	dent's Usual Occu	pation during most of world)	king	16b. Kind of Business/I	ndustry	
12	2 should be filed within? n and Mental Hygiene. I's marked other than "reumatic avent, the Med		Elementary/Secondary (0-12)	College (1-4or 5+)	Carpe		ia)		Senate		
d	Hygi other	Be Co	17. Father's Name (First, Middle, Last)		Carpe	псет	18. Mother's Nam	ne (First, Middle,	Maiden Sumame)		
lan lan	fenta fenta rked ric av	To B	Robert B. Welsh				Florence				
Maryland	2 should had had had had had had man	ļ -	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Stree			er, City or Town, State, Z.	ip Code)	
	1 and 2 Health tem 27 I		Betty Welsh (Wife)				Rd. Wood	bine, MI	21797		
Baltimore,	Pages 1 nent of He ant: If iter ary or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)			sition (Name of matory or other plate) Ridge Ce		Date 18/2005	20c. Location - City or T Woodbine, M		
Balt	permit. Pag Depertment Important: I eny Injury o		21. Signature of Funeral Service Licent	7	2:	2. Name and Addr	ess of Facility				
			23a. Part 1. Enter the disease or comp	lications that caused the dea	I 2	IZ W. OI	d Liberty	Rd. Wir	and Cremato		
	Pny <del>sicia</del> n /Medical	/Medical Examiner	25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  a. END STACE  Due to (or as a consequence of):								
	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c								
	cuted nd rransit										
,092	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):						
68	leath certificat attending phy ifor use as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	ancy				2015		
P.O. Box	that the death red by the atter detached for u	Physician/Med	in the past 12 months?  1						23d. Date of delive Month	Pery Day Year	
	es g								tobacco use contribute to the cause of death?		
Records,	The law requir	Completed by							rmed? prior to co	opsy findings available ompletion of cause of	
Vital	iclan: Th certificate ector, pag	BeC	25. Was case referred to medical				26. Place of Dear		2 ☐ No 1 ☐ Yes	2L] NO	
of V	S S	일	examiner? 1 Yes 2 10	lospital: 1 [hpatient 2	] ER/Outpatier	nt 3 DOA			lence 6 Other (Speci	ify)	
ion o	nding Phy eth. r: After thi		27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M		Wo	28c. Injury at Work? 28d. Describe how				
Division	al or Attends efter deeth	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attending within 24 hours effer deeth.  To the Funerel Director: Atter completely filled in by the funer	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the o	cause(s) and manner as dato and place, and due t	stated. to the cause(s)	
	To the To the comp	Me	29b. Signature and title of certifier			29c. Licen			29d. Date signed (Month,	Day, Year)	
)	~		I levely	4		DO	0545	80	5/15/05		
5	112		30. Name and address of person who co	HAR, M.D.	417	Print) BA	0545 -TIMORE	ST	# D, TA	NEYTOWN MI	
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 8 20	32 Registrar's Sign	ature A	erfe On				21787	

Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey **Physician** am 26, 2005 George Kojo Aikoo, Jr. April 9:02 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Genesis Eldercare- Layhill Center Silver Spring Montgomery 8. Date of Birth (Month, Day, Yeer) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. lest birthday) Birthplace (Stete or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 1 M 2 □ F Days Hours 53 Yrs. 578-78-4173 July 9, 1951 Ghana Director Usual Residence of Decedent death with the Marylend 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County **ehow** Pegas 1 end 2 should be filed within 72 hours aftar death with the Maryle nant of Health end Mantel Hyglene. Int: If Item 27 ie marked other than "natural", or itema 23a or 28a-f ehou int: If Item 27 ie marked other than "natural", or itema 23a or 28a-f ehou into or other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 H No Directo Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 13601 Athania Street 20906 Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify:Black 1 Yes 2 XNo Specify Saltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Custodial Maintenance Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George K. Aikoo Afua Abrefi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) George K. Aikoo, Sr./ Father 13601 Athania Street, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date May 7 20a. Method of Disposition Depertment of important: If it any injury or or 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Juneral Service License Prancis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, Md 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Head and Neck Cancai /Medical Egys Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed ettending physician and for use es the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No þ 9 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificata has 3/4 No 1 ☐ Yes 2 ☐ No ours after death.

The Director: After this certification by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Deeth 28b Time of 28c Injury at Work? Attending 1 Accident 5 Pending 2 □ No 1 TYes investigation 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide e Hospital or At n 24 hours after on Funerel Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cand menner stated. edical 29a. Certifier (Check only one) mination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) To the within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MUD 30262 200 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) TT esearch )HIRA 401

State Registrar

. Registrer's Signeture 31. Dete filed (Month, Day, Year) 04 2005

			Please I	State of Maryland / De		•	•		
			For State Registrar	· ·	ertificate of Death		Reg. No.	16788	
			Decedent's Name (First, Middle, Last)			2. Date of De	aath	3. Time of Death	
	Physicia /Medic	cal	Harvey	Anderson, Jr	•	April :	27 2005	3:53 P M	
	Examin		4a. Fecility Name (If not institution, give s		4b. City, Town, or Location of Dea	th	4c. County of Death		
			Villa St. Michael'	s Nursing Home 7. Age (In yrs. last birthda	Baltimore y)	s. 8. Date of Bir			
	Funeral		5. Social Security Number 6. Sex 1128	ay, Year) Cou	place (State or Foreign intry)				
	Director	4	Usual Residence of Decedent	M 2 F 65 Yrs.		April	23 <b>,</b> 1940 Ge	orgia	
	yland		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits	
	e Mar	ctor	MD. Howard	Ellico	tt City			1 ☑ Yes 2 □ No	
	ith th	Director	10e. Street and Number		10f, Zip Code		10g. Citizen of What Cou	intry?	
	s 23a		8700 Ridge Road #		21043	Specify Vac or No	USA 14. Race - Amer	can Indian	
_	ther de	Funeral	11. Marital Status  1 Never Married 2 Married	1 ☐ Yes 2 ₩No	<ol> <li>Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue</li> </ol>	rto Rican, etc.)		, etc.	
Š	el', or	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Bla	ck	
ر ک	72 ho netur	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. Dec	cedent's Usual Occupation we kind of work done during most of wo DO NOT use retired)	orking	16b. Kind of Business/li	ndustry	
2	vithin ne. han *	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)			U.S. Govern	ment	
N	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel; or Items 23a or 28e-f show ant, Ire Miclical Examiner must be nufficed at		17. Father's Name (First, Middle, Last)	3 yrs, St	ipervisor 18. Mother's Na	ame (First, Middle	, Maiden Sumame)	merro	
<u>a</u>	should be nd Mental marked o imatic eve	To Be	HArvey Anderson	. Sr.	Savanr	ah Con	vers		
a Z		-	19a. Informant's Name/Relationship (Typ		iling Address (Street and Number or F		4	p Code)	
Ξ.	and 2 ealth a n 27 is		Reginald Rogers/At		Frost Drive, Bow		20720		
Baltımore, Maryland 21215-0036	of He		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Re	20b. Place of Dis cemetery, c	position (Name of rematory or other place)	Date	20c. Location - City or T	own, State	
Ē	Pag tment tant:		' 4 ☐ Donation 5 ☐ Other (Specify)	Wash. Me	emorial Gardens 5-		Decatur, GA		
a	permit. Pages Department of H Important: If Ite any injury or of 2005e.		21. Signature of Funeral Service License	0 00		-	s Funeral H		
			23a. Part / Enter toe disease, or complic	cations that caused the death. Do not a	4217 9th. St. N.W.			Approximate	
	Pnysician ·		shock or heart failure. List only on Immediate Cause (Final		deienen Virus			Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Human Immunode f  Due to (or as a consequence of):	ictency virus				
	Examiner		Sequentially list conditions, b		iciency Virus Dem	entia			
	sit ød	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of).  Avascular Necrosis Right Hip  Due to (or as a consequence of):						
•	be executed sicien and burial-transit	xan							
9/	e be executed /sicien and e burial-transit	calE		Benign Prostati	ic Hypertrophy				
9	ettending physic		IS SENANCE						
Box	death certificat e ettending phy of for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	ery Day Year	
о П	0 0 0	sici	1 🗆 Yes 2 🗆 No 9 🗆 Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)		Worth	Day real	
٦.	The law requires that the de ste has been signed by the c page 2 should be detached to	Ph	Part II. Other significent conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did 1	tobacco use contribute to	the cause of death?	
ďS,	uires I sign	d by	Cardio Pulmo	nary Arrest		1 🗆	Yes 2⊠No 3∏Pro	babiy 4 🗀 Unknown	
00	w requ	Completed				24a. Was		opsy findings available	
Re	The lav		929			auto perfo	prior to control death?  25 No 1 □ Yes	ompletion of cause of	
Ita		Be C	25. Was case referred to medical examiner?		one)				
<u>&gt;</u>	N S D	To	1 ☐ Yes 2 🔀 No	ospital: 1 Inpatient 2 ER/Outpat			idence 6 □Other (Spec	fy)	
Division of Vital Records,	Attending Physicien: ir death. ector: After this certific by the funeral director.	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Yeer) Injur	y Work?	28d. Describe	scribe how injury occurred		
Sic	vttendi death. ctor: A y the fi	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,	M 1 ☐ Yes 2 ☐ No	28f. Location (	Street and Number or Rui	al Route Number.	
Ω	ofter Olred	Certification:	4 Homicide determined	building, etc. (Specify)		City or To	wn, State)		
	To the Hospitel or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral			icien: To the best of my knowledge, de					
	the Ho in 24 the Fu	Medical	(Check only 2 Medicel Examir one)	ner: On the basis of examination and/or and manner stated.		curred at the time,			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License number D 30115		29d. Date signed (Month		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					May 4, 2005				
(	K (2)		,	mpleted cause of death (Item 23a) (Typ Ohiokpehai, M.D. 2	· ·	Ave Ral	timore Md	21215	
	Sta	te	31. Date filed (Month, Day, Year)	82. Registrar's Signature		LIVE. Dal	CIMOLE, PIG.	21213	
	Registr		MAY 0 5 2005	Glace & for	We .				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2005 Year April 28, **Physician** 4; 30am William M. Armistead /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges 3524 Chadwick Ct. Temple Hill Months Days Hours Min. Dec. 16, Yaaa 34 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1√2 M 2□ F 70 Plymouth, N.C. 243-46-8300 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits in than "naturel", or items 23a or 28e-f show the Medical Examiner must be nutified at 1.☐ Yes 2 ☐ No Directo Maryland | Prince Georges Temple Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 United States 3524 Chadwick Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Private 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) Milton Armistead <u>Annie</u> Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3524 Chadwick Ct. Temple Hills, Md. Julia Armistead /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State May 2, 2005 Clinton, Md. Resurrection \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22 Alexander 5. Pope Funeral Homes, P.A. Part 1. Inter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike/Forestville, Md. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MEMSTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2/1No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 HO 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Divatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier # PML 30, 2005 30. Name and address of person who completed cause of death (It 23a) (Type, Print) BELTS VILLE 31. Date filed (Month, Day, Year) 32. Registrar's SignatuTe State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** Lindalee Cheek Binswanger April 29, 6:20 рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare- Layhill Center Silver Spring Montgomery 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 M 2 X F 578-30-7928 Director 1928 Washington, Jan. 12, Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location al', or items 23a or 28a-f show Even ther must be polified at 10d. Inside City Limits Maryland 1 Yes 2X No Montgomery Wheaton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13310 Foxhall Drive 20906 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced Year or Dates "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home nit. Pages 1 and 2 should be filed a artment of Heatth and Mental Hygie ortant: If item 27 Is marked other? injury or other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leland Haney Cheek ပ Rosalie Linda Gulli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13310 Foxhall Drive, Wheaton, Maryland 20906 of Disposition (Name of Date 20c. Location - City or Town, State William B. Binswanger/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 4, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2005 Silver Spring, Maryland 21. Signature at Funeral Service Licensee F22 Name and Address Collins Funeral Home Inc Robert E Kan 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that covered the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The taw requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Seizure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 No 1 Yes 2 No : After this certification : After this certification. or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. title of certifier 29d. Date signed (Month, Day, Year) 29b Signature and 29c. License number D34472 May 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Toe, Pri Lynne Diggs M.D. 10400 Connecticut Avenue, #206, Kensington, MD 20895 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 04 2005 Registrar

			1 - For State Registrar		Marylar		artment o					g. No.	05	167	91
	Physici /Medi		Decedent's Name (First, Middle, Howard B	rown, Jr.						2.	. Date of Death Month May	Day 3	Year 2005	3. Time of 2:38	Death A M
	Examir		4a. Facility Name (If not institution,	give street and num	ber)		4b. City, To	wn, or L	ocation of D	eath	ria,		y of Death		
			Prince Georges	Medical (	Center		Cheve	rly				Pri	nce G	eorges	S
	Funeral			6. Sex 7 1 ☐ M 2 ☐ F		last birthday)	If Under 1 \ Months D		If Under 24 I Hours A	Hrs. 8. Jin.	Date of Birth (Month, Day,	Year)	9. Birthpli	ace (State o	or Foreign
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	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10	d. Inside Ci	ity Limits
	Mary fish	ţō	Md Prince	Georges		Dietri	ct Heig	h+a							2 No
	7.28e	rec	10e. Street and Number	ocorges		DISCIL	10f. Zip Co				10	g. Citizen of	What Count	TV?	
	h with	ai D	1848 Addison Re	oad South			20	747				USA		.,.	
	72 hours after death with the Maryland naturel', or items 23a or 28e-1 show altest Examinat must be multified at	Funeral Director	11. Marital Status	12. Was Deced	lent Ever in U	J.S. 13.	Was Deceden If Yes, specify		anic Origin	? (Specif	y Yes or No-	14. Ra	ce - America		
9	or ite		1 Never Married 2 Marrie		□ No		1 Tes, specity		Specify:	иепо ніс	an, etc.)		ck, White, e		
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12	within ane. then "	ğ	Elementary/Secondary (0-12)	College (1-	4or 5+)	1	ructio					16	1	. 1	
	filed Hygi other		17. Father's Name (First, Middle, L	ast)		Const	ructio			Name (F	First, Middle, Mi		employ	rea	
Maryland	12 should be filed within hand Mental Hygiene. 7 is marked other then "Ireumatic event, Ire Market	To Be	Howard D. Brow	√n					Mar	y E.	Sorre1	11	,		
ary	shound M	-	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (S	treet and		-	loute Number,		, State, Zip	Code)	
	ges 1 and 2 should be filed within 7: t of Health and Mental Hygiene. If Item 27 is marked other then "n. or other treumatic event, It e M. all		_Ethel B. Lewis	/sister							Distric				1.7
ore	of He of He roth	-	20a. Method of Disposition			Place of Dispo	sition (Name matory or othe	of		Date		Oc. Location			47
Ĕ	nit. Page entment ortent: If injury or		1 ☐ Burial 2 ☐ Cremation : 1 ☐ Donation 5 ☐ Other (Sp.				11 Cem		y 5/	7/05	Cox	ingto	n. Va		
Baltimore,	permit. Pages 1 and 3 Department of Health Importent; if Item 27 any injury or other tr once.		21. Signature of Funeral Service L	icensee	20	2:	2. Name and A	ddress	of Facility	Mars	hall's	Funer	al Hon	ne	
-	207		23a. P. Enter the disease, or c	arsha	M						h. D.C.		1		
8760,	Physician pe executed using physician and physician and areas the purial-transit	cal Examiner	k, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Usease or injury that initiated events resulting in death) Last	a. Lung Due to (o  b. Due to (o	r as a consec	quence of):								Interval Bett Onset and C	
P.O. Box 68	the death by the atter ached for u	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta nt at time of d	al death 3[	Ectopic pregr Other (specif						ite of deliver onth	,	'ear
	w requires that been signed I should be det	ed by P	Part II. Other significant condition	s contributing to dea	th but not res	sulting in the u	nderlying caus	e given	in Part I.	_	23e. Did toba 1 ☐ Yes	cco use con	tribute to the	5.4	eath? Inknown
il Records,		Completed								_	24a. Was an autopsy performe	ed?	Were autop: prior to com death? 1 \(\sum \) Yes \(\frac{2}{2}\)	sy findings a pletion of ca	available ause of
Vital	yslcien: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:					6. Place of I	Death (C	check only one)				
of	S S	٦.	1 ☐ Yes 2 🗶 No 27. Manner of Death	1 □ Ini		ER/Outpatier	-				5 Residen				
Division	ding After fune	Certification;	1 XNatural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	ation at he	Day Year)	28b. Time of Injury	М		s 2 No		I. Describe how				
Div	urs after are Direction by		4 Homicide determin	building	, etc. (Speci	fy)	reet, factory, of				Location (Stre City or Town,	State)			ber,
	To the Hospital or Attan within 24 hours after deatl To the Funerel Director: completely filled in by the	Medicai	(Check only 2   Medical E.	Physician: To the base and manner	is of examina	owledge, deatl ation and/or in	vestigation, in	my opini	ion, death o	ace, and ccurred a	at the time, date	e and place,	and due to t	he cause(s)	)
	7 × 00		29b. Signature and title of certifier	, //				cense n		-		1. Date signe			
	0 10	1	Igm a	1 Ven				000	0335	2		9	0-6	10	
C	MO		DR KAYMOND LUC	ho completed cause	of death (Iter	m 23a) (Type.	Print) P, TAL	DK	2	C	HEVERL	, MD	20%	185	
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 0 5 20	05 Sec.	Jistrars Signa	Span	B								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 0 0 5 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1505+ R Death 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location 4c. County of Death **Examiner** purde 6/00 Burpie 50- C If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 1 DM 2□ F Months Days 237 - 64 - 9339 Usual Residence of Decedent SUMPTER SC 64 Yrs. Director 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov if item 27 is marked other than "natural", or items 23a or 28a-f shor or other treumstic event, the Medical Examinar must be notified at 1 Yes 2 No Director VA ALEXANDRIA 10e. Street and Number 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. 101 23214 DUCEN ST # by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after v Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than "natural", or iter any injury or other treumatic event. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: BUACK 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) CONSTRUCTION Elementary/Secondary (0-12) College (1-4or 5+) ONTRACTOR CUSANER 13 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be mccoy BEST EDOJE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTEMORE, MD 2121 20b. Place of Disposition (Name of cemetery, crematory or other place) E. LADVALE ST CORA BEST/WIPE 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 6-7-05 SANFIRD NC 4902 Stan Haven Rd md 20748 4 ☐ Donation 5 ☐ Other (Specify) WHITEOAK COMCREY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jemple Hills 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner moscleratic sate has been signed by the attending physician end page 2 should be deteched for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 3 Probably 4 knknown 1 ☐ Yas 2 ☐ No þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 2\□\No 1 Tyes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ FR/Outpatient 3 ☐ DOA ဥ **Director:** After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural To the Hospital or Attending within 24 hours after death. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier Deputy 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) JONES 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 16 Ray 6/95

State

Registrar

0 4 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Lillian 5:20 a M Peper Crawford 1, 2005 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9222 Woodland Drive Montgomery Spring If Under 24 Hrs. Silver 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF 218-38-9316 Director March 14,1905 100 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Montgomery Directo Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9222 Woodland Drive 20910 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No by Specify: Specify: White 3 Nidowed 4 Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ex is marked John Henry Theodore Peper Johana Sophia Dietzel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10771 Middleboro Drive, Damascus, MD 20872 Charles L. Crawford/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 6, 2005 Fort Lincoln Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Juneral Service Licenses Francis dess Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final **Physician** Congestive Cardiomyopathy 2 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease 1 Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): attending physicien of for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 2 🗆 No peu the 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Brachycardia due to Conduction System 1 Yes 2X No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Disease has page 2 autopsy certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No Director: / investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a Medical XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -Cel D33159 May 2, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruth Kevess-Cohen, M.D. 8900 Georgia Avenue, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) Registrar's Signature State market MAY 04 2005 Registrar

			State of Maryland / Department of Health and M  State Certificate of Death		iene 005	16794
			Decedent's Name (First, Middle, Last)	2. Date of Deat	h	3. Time of Death
П	Physici		BING RUI CHEN	APRIL	26, 2005	5:07 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1111 1111	4c. County of Death	3.07 11
	LAGITIII		Washington Adventist Hospital Takoma Park		MONTGO	MERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	year) 9. Birth	pface (State or Foreign
	Director		213-69-5668	July 2	9. Birth Cou.	hina
	pur *	}	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	shor	ក	MD Montgomery Rockville			1 ☐ Yes X☐ No
	the N	Director	10e. Street and Number 10f. Zip Code	1/	0g. Citizen of What Cou	
	with a or		12615 Veirs Mill Road 20853	'	U.S.A.	•
	ns 23	Funerai		cifv Yes or No-	14. Race - Ameri	
10	r Iten	필	Armed Forces? If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Bfack, White,	
93	urs a el', o	þ	If Yes, Give 1 ☐ Yes 2 No Specify: Year or Dates:		Specify: AS	sian
21215-0036	n 72 hours after death with the Maryland "neturel", or Items 23a or 28a-f show cited Examiner must be netitled at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working the completed)	20	16b. Kind of Business/In	dustry
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2		Co	12th Unemployed	(m)		
Maryland	be filed tal Hyg ad othe event,	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  Ch			
3	should be nd Mental marked o	10		J	la	0-41
Mal	12 sh h and 7 Is n treun	8 1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura  Chao, Viv. Chao, (Doughtors)		-	
e,	Healt Healt	1 3	Shao Yu Chen (Daughter) 12516 Veirs Mill Rd  20a. Method of Disposition (Name of cometery, crematory or other place)		20c. Location - City or T	
20	ages nt of nt of	1	1 X Burial 2 Cremation 3 Chemoval from State		·	
Baltimore,	artme orteni injury	1	. 4 □Dopsylon 5 □Other (Specify) Park awn Mem Park 4/3 21. Signature Funeral Service Lice 1969 22. Name and Address of Facility Sno			
Ba	permit. Pages 1 and 2 should be Department of Health and Menia Importent: if item 27 is marked eny injury or other treumatic events once.		Place A Sall SQL 246 N. Wash. St.			•
			23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o		-	Approximate
	Physician		Immediate Cause (Fidal disease or condition as Coronary Catheriscless)			Interval Between Onset and Death 7 5 VECCTS
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):			15/20151
	Examiner		Sequentially list conditions b.			
	₽ ≈	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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50,	be executed sician and burial-transit	Ē	resulting in death) Last Due to (or as a consequence of):			
8760,	ate hy:	dicai	d			
9 X	eath certific attending pl	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	env
Вох	atten atten i for u	cian	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy		Month	Day Year
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	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edicai	(Check only one)  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time, da	ate and place, and due t	o the cause(s)
	o the	Me	29b. Signature and title of certifier 29c. License number	25	9d. Date signed (Month,	Day, Year)
	4		Cores Killing M.D. D0057030	<b>+</b>	12pril 27,	2005
	_ (		29b. Signature and title of certifier  Cores (Lu. L.D., DOO 57036  30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)  Greg Krykuntan 6116 Executive Blvd, Suite	1000 10	mak . 110	111 20002
_			Greg Kunkunton 6116 Exentine Blue , Suite	155, K	DOLLINITY,	LID MOSE
	Sta		31. Date filed (Month, Day, Year)  32 Registrar's Signature			
	Regist	rar	MAY 0 4 2005 Some & Marie			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrer Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** necc 0 1a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TON If Under 24 Hrs. ME  $m_{DK}$  Birthplace (State or Foreign Country) Security Number 6. Sex (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 F 9-0 Director VOV. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic evant, if a Medical Erasulter insust be notified at 1 PYes 2 No Directo albot ppe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 A 1e Alvenue Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 🗆 Yes 2 No Maryland 21215-0036 Specify Specify: 3 Widowed 4 □ Divorced 1ack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Worker rivate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Noses 2 Yarriet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 86-Main Street Trappe, Maryland 216 Kobert hase eon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Paradise Cometery! 5/0 4 ☐ Donation 5 ☐ Other (Specify) Trappe, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P. A. MD21613 Cambridge 510 Washington Sti Approximate Interval Between Onset and Death 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician SEPSI /Medical Due to (or as a consequence of) Examiner Ur, nory Tract Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed be detached for use as the burial-tran Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown ģ Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 to 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Anpatient 3□ DOA Certification: To 2 ER/Outpatient After this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 ANatural 2 No 1 Yes within 24 hours after death.

To the Funeral Diractor; A completely filled in by the fu 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 30/05 039749 wer mo

State Registrar 31. Date filed (Month

503 Cynwood Drive, Easton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005<sup>2. Registrar's Signature</sup>

Greg Oliver, M.D.,

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Loraine W. May 2005 11:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Hospital Cheverly Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1/16/1932 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1₩ 2□F 579-56-3705 73 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, If Medical Events 1000. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1X Yes 2 ☐ No Directo Maryland Prince Georges District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1746 Forest Park Drive 20747 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black Specify: Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Birttie Lewis Magdalene Pincham ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 Westway #103; Greenbelt MD 20770 Deborah Pullen - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 5/9/2005 Brentwood, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Musclint, Wolfer Fort Lincoln FH 3401 Bladensburg Rd; Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREATIC **Physician** /Medical Due to (or as a consequence of): SERSIS Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consuluence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA ASCITES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe COAGLLLOPATHY 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D55103 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BERHANE CHEVERLY, MD MD T510N 3001 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

	,	For State Registrar	State of M	Maryland .			of Health a of Death	and Men		jiene	05	16797
		Decedent's Name (First, Middle,	Last)						ate of Dea		.,	3. Time of Death
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/Medic Examin		4a. Facility Neme (If not institution,		r)	T	4b. City, Tox	vn, or Location of		<u> </u>	4c. County		0.100
Examin	er	Sunbridge C	•			E 1	kton			Ceci	1	
Francis				Age (In yrs. last	birthday)	If Under 1 Y	ear If Under	24 Hrs. 8. D	ate of Birth			lace (State or Foreign
Funeral Director		218-54-1389	1 □ M 2√2 F	97	Yrs.	Months D	ays Hours	Min. Ju	$\mathbf{ne}^{Donth, Day}$	, 1907	MD	ntry)
		Usual Residence of Decedent										
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Mar Fish	ţò	MD Cec	i1	N	orth	East						1 ☐ Yes 2 No
r 28g	ie	10e. Street and Number				10f. Zip Co	de	-	1	0g. Citizen of V	What Cour	ntry?
h witi	Funeral Director	189 Plum Cre	ek Rd.			219	01			U.S.	Α.	
deat deat	ner	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13. V	Vas Deceden	of Hispanic Ori Cuban, Mexican	gin? (Specify	Yes or No-		e - Americ	an Indian,
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Men Men arka	10	Joseph	Metzger					rie R				
ite; Intally land ZILIO-OOOO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural; or Itams 23e or 28e-1 show other traumatic event, Ite Medical Examinations the rediffied in		19a. Informant's Name/Relationsh					treet and Numbe					
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of He control		20a. Method of Disposition 1   Burial 2 □ Cremation	3 DRemoval from Sta	20b. Plac	e of Dispo: etery, crep	sition (Name natory or othe	of Concept	Date	v e	20c. Location -	City or To	own, State
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Dealthinote, Williams, Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		21 Signature of Funeral Service L	.icensee	K.C.	22	Name and	ddress of Facilit	ee Fu	nera	1 Home		
0 89E88	0.0	- File			- 1	259 I	. Mair	St.	E1k	ton, M		21921
		23a. Part1. Enter the disease, or on shock, or leart failure. List of	complications that caus	ed the death. I	Do not ente	er the mode o	f dying, such as	cardiac or res	piratory are	rest,		Approximate Interval Between
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ondin use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic preg					te of delive	*
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spita ours naral		29a. Certifier 1 Certifyin	g Physician: To the be	est of my knowle	edge, death	n occurred at	the time, date ar	nd place, and	due to the	cause(s) and ma	anner as s	tated.
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X		30. Name and address of person v	who completed cause of	of death (Item 2	За) (Туре,		<b>A</b> 1				-1-	· · ·
V (		Christic E.K.	Hugh N		UID S	Saharka	a Plaza	_ , N	ework	- DE	1911	<i>i</i>
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298	33		For State Registrar	State of Mar		partment of ertificate of		d Mental H	ygiene Reg. No.	2005	15700
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, L CHARLES 4a. Facility Name (If not institution, g Route 197 @ Muir	D. C	RAIG	4b. City, Town, Laurel	or Location of D	2. Date of Danish April	30, Day 4c. C	2005 Year County of Death Ince Geo	3. Time of Beath 0315 A M
	Funeral Director		717 JO 003E	Sex. 7. Age (1	In yrs. last birthda Yrs.	y) If Under 1 Year Months Days		8. Date of 8 (Month 2 8 - 2 - 6 9	irth lay, Year)	9. Birthi GA	place (State or Foreign ntry)
	e Maryland ta-f show	ctor	Usual Residence of Decedent	GEORGE	Oc. City, Town or						10d. Inside City Limits 1X Yes 2 ☐ No
5-0036	be filed within 72 hours after death with the Maryland stal Hygiene. ad other than "natural", or Itams 23a or 28a-f show avent, the Medical Eyer if were nast be truffiled at	eted by Funeral Director	10e. Street and Number  7529 BUCHANAN  11. Marital Status  XXX Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's (Specify only highest of	12. Was Decedent Ev. Armed Forces? 1	16a, Dec	1 ☐ Yes 2 <b>X</b> No	Hispanic Origin ban, Mexican, P o Specify:	? (Specify Yes or Nuerto Rican, etc.)	U. 14	S. A.  4. Race - Americ Black, White,  Specify: BLA  d of Bushan	can Indian, etc.
Maryland 21215-0036	be filed withIn tal Hygiene. d other then "	To Be Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, La  UNKNOWN	College (1-4or 5+) 2 YRS.		ve kind of work done DO NOT use retir	18. Mother's	Name (First, Middle  JDETTE CR.	PLANN le, Maiden S	NING CON	MISSION
	d 2 th a		19a. Informant's Name/Relationship CLAUDETTE CRAIG	(Type, Print)		-		N. E.			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Service Lice)	□Removal from State cify)	cemetery, c		RK 5-	Date -5-05 PINCKNEY I. E. WA	LANDO		DIERAL HOME
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8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dical Examiner	Sequentially list conditions, Lay, leading a immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a d							
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2↓ 4□Pregnant at tin 9□Unknown	Fetal death	B⊟Ectopic pregnan Б⊟ Other (specify)	су		23	3d. Date of delive Month	ery Day Year
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	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	29a. Certifier (Check only  29b. Sign tun and ittle of certifier	Physician: To the best of aminer: On the basis of examiner state	kamination and/or	investigation, in my	time, date and p ropinion, death of nse number	occurred at the time	e, date and p	olace, and due to signed (Month,	o the cause(s)
0	(5)		30. Name and address of person with	o completed cause of dea	th (Item 23a) (Typ	O.C.				30, 20	05
1	Sta Registr		31. Date filed (Month, Day, Year)		s Signature	nn Street	, Balti	more, Mar	y Land	21201	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day Year **Physician** Trigg Kato Cheek April 30,2005 1:15am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Laurel Reginal Hospital Laure1 Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Sociat Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 □ F Yrs. 578-42-9310 Director April 22,1934 Washington DC Usuat Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No DC Washington DC Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3001 Bladensburg Rd. N.E. #620 United States 20018 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 文 No Specify: Specify: Black Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than College (1-4or 5+) Elementary/Secondary (0-12) Driver Private 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othhany any liquy or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Evander Cheek Annie Graves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Trisa Cheek-Boyd /Daughter 3714 Hayes St. N.E. Washington DC 20019 #203 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Donation 5 Cremation 3 Removal from State 1 Donation 5 Other (Specify) Quantico National Cem May 5,2005 Triangle, VA 22. Name and Address of Facility
Alexander S.Pope Funeral Home e of Funerat Service Licensee 2617 Penn. Ave S.E. Washington DC 20020 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Finat disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence ot): Examiner Bilateral Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and I-transit The law requires that the death certificate be executed Chronic Obstructive Pulmonary Disease Due to (or as a consequence ot): Physician/Medical Arterial Fibrillation the as nding IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atten 2 Fetal death 3 Ectopic pregnancy Month Day ō 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 XNo 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 2 No certificate 2**X** No 1 Yes 1 Yes 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident neral Director: 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3 12005 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 Van Dusen RD #220 aurel 31. Date filed (Month, Day, Year) State MAY 0 4 2005 Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.O.

Amend item 4a per phys 843 5-18-05 vt state of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month NEWBERRY CARTER, JR. 7:15 A<sup>™</sup> /Medical April 09. 2005 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST CHURCH Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X**M 2□ F Director Yrs. 579-46-7996 1936 Washington, D.C. Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumetic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No D.C. Washington the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5 or items 23a 324 "U" Street, N.W. 20001 death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: "natural" **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Custodian D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental ဂ Newberry Carter, Sr. Elizabeth Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Beverly Ann Carter/wife 1723 Village Green Drive Landover, Md. 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 3, 2005 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Deportment of Importent: If any injury or once. Arlington Nat'l Cemetery Arlington, Virginia 21. Sigrature of Funeral Service Licensee 22. Name and Address of Facility

Frazier's Funeral Home.Inc. 389 Rhode Island Ave., NW Wash., DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ouset an Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Khown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attanding Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No ö 1 Impatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident hours after deat 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a

To tha Funeral C

completely filled 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) WASHING

State Registrar

RABYN

31. Date filed (Month, Day, Year)

32. Registrar's Signature ORIGINAL

CARRICE

7600

D. ANDERSON

MAY 1 8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6.20 Pauline Darcangelo deHuarte 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Worcester Atlantic General Hospital Berlin If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐XF March 28,1931 Washington, DC Director 74 577-42-4279 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be illed within 72 hours atter death with Department of Health and Mental Hygiene important: if itam 27 ie marked cither than "naturat", or items 23e or any njury or other traumatic event, the Medical Examire must be 9008. 6 Crossbow Trail 21811 US K 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes **3€** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Darcangelo Florence Marino ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina deHuarte 6 Crossbow Trail, Berlin, Md. 21811 Tos oc. N Baltimore, N 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 □ Donation 5 □ Other (Specify) Gate of Heaven Cem. 5-10-05 Silver Spring, Md. 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 Pail . Enter the dilease, of complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** LONGE 2 402/5 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or Jerfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 □ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{Specify} \) 2 No Certification: To 1 Tyes 1 Impatient 2 ER/Outpatient 3 DOA After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: , I in by the f 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cyse of de iih (Item 23a) (Type, Print) Hellhury 9733 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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05-3071 B.K.S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Departme	nt of	Health	and	Mental	Hygiene.	U
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JUSTIN	L. DON	IAW	AY For State Registrar	State of	Maryland		irtment of F		nd Men	tal Hy			05	166	30
	Physici	an	1. Decedent's Name (First, Middle, La	,			imouto or	Douin		ate of De		Day	Year	3. Time of	f Death
	/Medic Examir	cal	Justin L  4a. Facility Name (If not institution, give	e street and num	nber)		4b. City, Town, o		Death	<u> </u>	3, 2	2005 4c. Count		1705	P
	Funeral		ATLANTIC GENERAL  5. Social Security Number 6. S	ex	AL 7. Age (In yrs. la	ast birthday)	BERLIN  If Under 1 Year	If Under 2		ate of Bi	rth		ESTE 9. Birth	R place (State o	or Foreig
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920	rurs after d al', or Iten Examinat	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For 1 Tes If Yes, Give Year or Da	ces? 2A∑No e		Vas Decedent of H Yes, specify Cub ☐ Yes 2√2 No	an, Mexican,  Specify:	Puerto Ricar	n, etc.)	J-	Bla	ck, White,	etc.	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I Health and Mental Hygiene. I Health are 1838 or 28a-f show other traumetic event, the Madical Examinal must be natilised at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-	4or 5+)	(Give	ent's Usual Occup kind of work done OO NOT use retire	during most of	of working		16b.	Kind of B	usiness/Ir	ndustry	
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ylan	Mental Mental arked c	To Be	Donald Lee Dor		r.				ıra Gl						
Marj	d 2 sho		19a. Informant's Name/Relationship (  Laura Donaway	Гурө, Print)			g Address <i>(Street</i> Nottingha								
ore, l	permit. Pages 1 and 2 s Department of Health an Importent: If item 27 le eny injury or other trau <u>once.</u>		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from S	1 00	ace of Dispos	sition (Name of patory or other pla	1	Date Date	ean				own, State	
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å	Perm Copp Copp		N. Suil /S	mbas		IC	8 Willian	St.,	Berlii	η, M	d.		iici a	1 Home	-
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Vita	ıysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  ¹X Yes 2 □ No	Hospital:	× ×	'D'O	oth Oth	or.	of Death (Che						
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Div	s after s after ol Direct	Certification:	4 Homicide determined	building	g, etc. <i>(Specify)</i>	hom	et, factory, office		C	ity or To	wn, Sta	ite) (6	Notti	al Route Numi	Lan.
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	F 0		30. Name and address of person who	completed cause	of death (Item	23a) (Type, F	Print) _ =								
بع	1 0		CAROLH. AZ 31. Date filed (Month, Day, Year)	2/1000	gistrar's Signati		111 Penr	Stree	et Ba	Ltim	ore	, Mar	ylan	d 2120	1
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_	Physic		1. Decedent's Name (First, Middle, Last)  Albury Elzey				2. Date of Death		3. Time of Death
	/Med Exami		4a. Facility Name (If not institution, give street and Dorchester General Ho			or Location of Death	7114	4c. County of Death Dorches	
1	Funeral Director		5. Social Security Number 218-16-8630 6. Sex 12 M 2	F 81 Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Nov. 17,		place (State or Foreign
	h the Maryland or 28a-1 show	ō	Usual Residence of Decedent  10a. State  10b. County  Maryland  Dorcheste:	10c. City, Town or				1	10d. Inside City Limits 1.□ Yes 2 □ No
R	death with the Maryland	i Direct	10e. Street and Number 2604 Shane Circle	-	Cambridge 10f. Zip Code	e 1613	10g	j. Citizen of What Cour	ntry?
5	and 21215-0036 <sup>1</sup> C C be filed within 72 hours after death with that Hygiene. Indother than "neturel", or items 23e or event, the Mydical Examinar must be	y Funeral Director	11. Marital Status 12. Was I Arme	es 2 No	1	Hispanic Origin? (Spec an, Mexican, Puerto R	rify Yes or No- lican, etc.)	14. Race - Americ Black, White,	
14	d 21215-0036 <sup>f</sup> filed within 72 hours atter Hygiene. Wher than "naturel", or Ite Mydical Examinant, the Mydical Examina	leted by	3 ☐ Widowed 4 ☐ Divorced Year  15. Decedent's Education (Specify only highest grade completed)	or Dates: WW 11	redent's Usual Occur		g 16	Specify: b. Kind of Business/Inc	White dustry
7	nd 212	e Completed	Elementary/Secondary (0-12)  7  17. Father's Name (First, Middle, Last)	Je (1-401 5+)	Employed			Shellfish	
Albun	Marylanc	To Be	Olin Elzey  19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street	Cec	ilia Wal		Code)
V	s 1 and 2 of Health a item 27 is		Dwayne Elzey/Son  20a. Method of Disposition	420 20b. Place of Disp	03 Saturn	Drive, Eas	st New M	arket, MD	21631
	Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tiem 27 is merked oth any injury or other treumetic event once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Licensee	MD Veter	ans Cemete	ery 5/4/20		urlock, Ma	ryland
	w solesa		23a. Parti Enter the disease, or complications in shock, or heart failure. List only one cause	at caused the death. Do not e	Curran-Bro 308 High nter the mode of dyir	omwell Fund St., Cambri ng, such as cardiac or	eral Homo idge, MD respiratory arrest	e, 21613	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Bilatera to (or as a consequence of):					Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of):					
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	Box 687 eath certificate attending phys for use as the		IF FEMALE: 23b. Was decedent pregnant 23c. If yes,	outcome of pregnancy				23d. Date of delive	
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	Reco	Completed					24a. Was an autopsy performed	d? death?	psy findings available appletion of cause of
	Vital sicien:	o Be C	25. Was case referred to medical examiner?  1  Yes  2 No  Hospital:	¶npatient 2 ☐ ER/Outpatie	ant 3 DOA Othe	26. Place of Death (	Check only one)		
	Division of Vital Records, To the Hospitel or Attending Physicien: The law requires It within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled.	ertification; T	27. Manner of Death  Natural 5 Pending  Accident investigation	tte of Injury fonth, Day Year)  28b. Time of Injury	of 28c. Injun	4 🗀 Nursing Home	d. Describe how i	e 6 Other (Specify, injury occurred	1
	Divisi To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director:	O	4   nomicide bu	ace of Injury - At home, farm, si alding, etc. <i>(Specify)</i>			City or Town, S.		
	the Hosp thin 24 hou the Fune mpletely fil	Medical		the best of my knowledge, dea b basis of examination and/or in anner stated.	nvestigation, in my of	oinion, death occurred	at the time, date	and place, and due to	the cause(s)
	Te wil		29b. Signature and title of certifier	MD		7924		Date signed (Month, D	
			30. Name and address of person who completed a NOMAN TITA NWY	300 AURO	Print)  ORA ST	REET	CAMAR	DCE M	12/6/3
	Sta Registr	- 2	31. Date filed (Month, Day, Year) 32 MAY 0 3 2005	. Registrar's Signature	books				

			For State Registrar	State of Marylar	-	artmen rtificat			ind M		Reg. No.	005	16804
	Physici /Medi	cal	Decedent's Name (First, Middle, Last)     RUT  4a. Facility Name (If not institution, give s	TH EILERT		4h Cilv	Town or	Location of		2. Date of De Month May 3,	2005	Year	3. Time of Death 6:00 A
	Examir	ier	Crofton Convelesce 5. Social Security Number 6. Sex	nt Center	last hirthday)	Croft	con	If Under 2		9 Date of Rid	Ann	e Arund	
Ŀ	Funeral Director			м 25xF 87	Yrs.	Months		Hours	Min.	8. Date of Birt Month, Da 12/25/	1917	Wash	place (State or Foreign ntry) D.C.
	e Maryland 3a-f show iffied at	ctor	MD 10b. County Prince Geo		y, Town or Lo pitol		ts						10d. Inside City Limits 1 X Yes 2 □ No
	3s or 2s	il Director	10e. Street and Number 2016 Grovewood Dro	ive		10f. Zip	Code 743				10g. Citize	en of What Cou A	ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other then "natural", or Items 23s or 28a-f show other traumatic event, the Medical Exentinal Premultible details.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:		Was Decedif Yes, special		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto l	cify Yes or No Rican, etc.)		Race - Ameni Black, White, Specify: Whi	etc.
Maryland 21215-0036	filed within 72 ho Hygiene. othar than "natur ant, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		16a Dece (Give life. Telep	kind of wo DO NOT u	rk done a se retired,	uring most )	of worki	ng		of Business/In	·
yland 2	should be filed ind Mental Hygi s marked othar umatic avant,	To Be C	17. Father's Name (First, Middle, Last)  Tasmer Pealow					18. Mother		(First, Middle, ode	Maiden S	'umame)	
	1 and 2 sho Health and Iem 27 Is ma		19a. Informant's Name/Relationship ( <i>Ty</i> ) Claudia A. Clark/I									ND 207	
Baltimore,	permit. Pages 1 a Department of Her Important: If item any injury or otha		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)		Place of Dispo emetery, crei dar Hi	matory or c	ther place	ry 5	/6/2	ate 005		ation - City or To and, MD	own, State
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	old				s of Facility ania Av	Ceuc	ar Hill F uitland,		Home,Ind 746	c <b>.</b>
8760,	death certificate be executed  Water and Market and Market are the burial-transit and for use as the burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq  Coronary Arti  Due to (or as a conseq  Due to (or as a conseq	uence of):  ry Dise uence of):								Onset and Death
O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ldeath 3□	Ectopic pr					23	d. Date of delive	ery Day Year
ords, P.	requires een sigr	by	Part II. Other significant conditions con Chronic Obstructive pu		ulting in the u	nderlying c	ause give	n in Part I.					ne cause of death?
Vital Records,	The fa ate has page 2	e Completed	25. Was case referred to medical					00 51	-4 D		sy med? 2 🖾 No	prior to cou death?	psy findings available mpletion of cause of
of	d is	To B	eyaminer?	ospital: 1  Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		Bc. Injury Work	r: 4 🙀 Nur:	sing Hon	(Check only on the 5 Residual	lence 6 [	□Other (Specif	y)
Division	o in in in	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory	, office		2	8f. Location (S City or Tow	itreet and i	Number or Rura	d Route Number,
	a Hospital 124 hours a 1a Funaral I	edical (	29a. Certifier (Check on one)  1 Certifying Phys 2 Medical Examir	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred vestigation	at the tim , in my op	e, date and inion, death	place, a	nd due to the o	ause(s) ar	nd manner as st lace, and due to	tated. the cause(s)
	To tha h within 24 To tha 3 complete	Me	29b. Signature and title of pertifier				. License			4		signed (Month,	Day, Year)
(	PI		30. Name and address of person who con	mpleted cause of death (Item	1 23a) (Type,		D570:	28			5-	-4~05	
	Sta	te	Aditya Chopra, M.] 31. Date filed (Month, Day, Year)	La Registrar s Signa	y Ave.	Ste.	231	Anna	poli	s, MD 2	1401		
	Registr	ar	MAY 0 5 2005	Dian 1	1								

busing		Registrar  1. Decedent's Name (First, Midd	fle, Last)		<del></del>	Death	2. Date of Death Month	e <b>g. No.</b> h Day Yeer	3. Time of Deat
hysici: /Medic		CLARENCE	ELLIS		JR.		APRIL	29 2005	1:20
xamin	er	4a. Facility Name (If not institution			4b. City, Town, or	Location of Death		4c. County of Deatl	
		4102 70th Av		(In yrs. last birthday)	Landover	Hills If Under 24 Hrs.	8 Date of Birth	Prince Ge	eorge's
neral ector		250-32-9710	1⊠M 2□F 76	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, August		nplace (State or For untry) th Caroli
>		Usual Residence of Decedent		0. Cit. T				3041	
Shov	ō	10a. State 10b. Count		Oc. City, Town or Lo					10d. Inside City Lin 1 1 Yes 2 □
Codiffi	rect	MD Prince	e George's	Landov	rer Hills		10	g. Citizen of What Co	
38 0	Ö	4102 70th Ave	enue		20784			U.S.A.	,-
or items	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-	14. Race - Amer Black, White	
arring.	by Fu	1 ☐ Never Married 2 🛣 Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 ★Yes 2 No	Army	1 ☐ Yes 2 🛣 No	Specify:			ack
E E	ed b		d Year or Dates:	16a. Dece	edent's Usual Occupa	ation	1	6b. Kind of Business/I	
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marked other than imatic event, the Me	Completed	9th			irtory Th	erpist		Private	<del></del>
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natic	၉	Clarence Elli		10h M-16	(04	Bertha V			
treum:		19a. Informant's Name/Relation <b>Dollie Ell</b>						City or Town, State, Z.s., Marylan	
Hem 2/18 marked other than maturel, of tems 2/3 of 28s-1 show r other treumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	,	20b. Place of Dispo				Oc. Location - City or 1	
ry or		1 □ Surial 2 □ Cremation 1 □ Other (			oln Cemet		/05 B	rentwood,M	arvland
any injury or c		21. Signature of Funeral Service			2. Name and Addres			ins Funera	
E & &	. 113	C (1	6		7474 Land	over Road	d Landove	r, Marylan	d 20785
dical niner transit the purial-transit	icai Examin	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. DIABETES  Due to (or as a c	consequence of):					
€ <u> </u>	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2   4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of delik Month	very Day Year
or use as	_	Part II. Other significant condit	ions contributing to death but in Pressure	not resulting in the u	underlying cause give	en in Part I.		acco use contribute to s 2 X No 3 ☐ Pro	
be detached for use as	by	nigh bioo					24a. Was an	24b. Were aut	opsy findings availa
should be detached for use as	by	High Chol	esterol					ed? death?	ompletion of cause
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			1_ For	State of M		/ Depa	artment of I	Health an	nd Mental H		9	1
			Registrar  1. Decedent's Name (First, Middle, L	ast)		Cei	rtificate of	Death	2. Date of		of UU5	3. Time of Death
	Physici /Medic Examir	cal	William Ignat 4a. Facility Name (If not institution, g				4b. City, Town,	or Location of D	Death	13	c. County of Death	12:50 AM
ı		Ш	Doctors Communi	ty Hospita		t for Tombbon of a col		anham If Under 24	Hrs O Date of	E I	Prince Ge	
L	Funeral Director		5. Social Security Number 6.  218-38-7914  Usual Residence of Decedent	Sex 7. Ag 1 M 2 □ F	ge (In yrs. lasi 63	Yrs.	Months Days		Min. 8. Date of (Month, 6/28	Day, Year	9. Birth Cou	place (State or Foreign ntry) ellville, Md
	death with the Maryland ms 23a or 28a-f show rmust be notified at	tor	10a. State 10b. County  Md. P.G		10c. City, T	own or Lo	ocation					10d. Inside City Limits 1 \( \overline{\text{Y}} \) Yes 2 \( \overline{\text{No}} \)
	or 28a	Director	10e. Street and Number		300	<b>,</b>	10f. Zip Code		-	10g. C	itizen of What Cou	ntry?
	eath w	Funeral	14812 Tongue I	AVENUE  12. Was Decedent	Ever in H.S.	13 1	207		2 (Specify Ves or	No.	U.S.A.	can Indian
0000	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. itam 27 Is markad other than "natural", or Itams 23s or 28a-f show other traumatic avant, if a Msdical Exertire must be notified at	by	1 □ Never Married 2€24Married 3 □ Widowed 4 □ Divorced	Armed Forces 1 ☐ Yes 2  If Yes, Give Year or Dates:	?		If Yes, specify Cub 1 ☐ Yes 2010No		n? (Specify Yes or Puerto Rican, etc.)		Black, White,	
0-017	filed within 72 ho Hygiene. pthar than "natur ant, ire Medical	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	f working	16b. I	Kind of Business/Ir	ndustry
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Mary	2 should be and Mental Is marked craumatic ave	-	19a. Informant's Name/Relationship				-	and Number o	or Rural Route Nur	nber, City	or Town, State, Zij	o Code)
e, e	1 and 1 Health am 27 thar tr		Shirley A. Ford/ 20a. Method of Disposition	Wite	-		Tongue .	Ave.,Bo	wie, Mar	-	20715	oum State
HOL	permit. Pages 1 and Department of Healt Important: If itam 2 any injury or othar once.		158urial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cem	etery, crer	matory or other pla Mem. Par		5/6/05		ndover, M	
Бантшог	rmit. F spartm iportar iy injur		21. Signature of Funeral Service Lice			_			& Sons C			u.
	8 Q E # 9		23a. Part1. Enter the disease, or co	Som	d Ab - d - Ab - 1	4	<u>925 Burr</u>	oughs A	ve.,N.E.	,Wash	ington,D	.C. 20019
	Pnysician /Medical Examiner	Examiner	shock, or heart fallure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate many. Enter those typics are the conditions of the cause (Fits those typics).	a. Liver l Due to (or as	Failure a consequent sis of a consequent	ce of): Live	r					Interval Between Onset and Death
O. DOX 00/00,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 0 9 \( \text{Uhrnown} \)	0.	of pregnancy	/ ath 3□	]Ectopic pregnanc ] Other (specify) _	у			23d. Date of deliv	ery Day Year
<u>,</u>	res that the de igned by the a be detached t	by	Part II. Other significant conditions		out not resultir	ng in the u	nderlying cause gr	ven in Part I.				he cause of death?
SOLUS,	v requir	eted	Thrombocyto	penia								pably 4 Unknown
ב ט	ysician: The law requires tha is certificate has been signed director, page 2 should be del	Completed			_					topsy rformed?	prior to co	ppsy findings available impletion of cause of
\ \ \ \	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Ott	ner	Death (Check onl			
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	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not determine	be 28e. Place of In	ury - At home c. (Specify)	, farm, str	eet, factory, office		28f. Location	(Street a	nd Number or Rura e)	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	Physician: To the best miner: On the basis of and manner st	f examination	dge, death and/or inv	n occurred at the ti vestigation, in my	me, date and p opinion, death o	place, and due to the occurred at the time	ne cause(s e, date an	s) and manner as s od place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	amo			29c. Licens				ate signed (Month,	Day, Year)
0	00		7-37		double fire and	-) (7		32769		may	2, 2005	
(	MY		30. Name and address of person who Ranjit Risam, M	D. 3060 N	Mitchel	lvil	le Road S	aiste 21	Bowie	, Mai	ryland 2	0716
Ŀ	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 200	5 S2. Registr	ar's Signature	free	B)	arte Z	10,			

			For State Registrar	State of	f Marylar		artmer rtificat					giene Reg. No.	05	16807
	Physici /Medic		1. Decedent's Name (First, Midd	^	anno	n				2	Date of Dea Month	Day	Year 2005	3. Time of Death
	Examir		4a. Facility Name (If not institution  Montgomery Go	on, give street and num	nber)		01	ney	Location of	of Death	7		ounty of Death	
	Funeral Director		5. Social Security Number  055-26-0809  Usual Residence of Decedent	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 7.4	Vre	If Under Months		If Under Hours	Min.	Date of Birt (Month, Day ug. 26	, Year)		nplace (State or Foreign untry) 7 York
	he Maryland (8e-f show officed at	Director	10a. State 10b. Count Maryland	Montgome:		ty. Town or Lo	lver		ng					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	Ba or 2	I Dir	10e. Street and Number 3005 S. Leist	ıre World I	31 <b>v</b> d. #	±3 <b>-</b> 819	10f. Zip	Code	2090	26		10g. Citizer	of What Cou USA	untry?
920	permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show may injury or other treumatic event, it is Medical Eventil art must be tredified at ODGE.	by Funeral	11. Marital Status  1 Never Married 2 1 Number 1 Number Married 2 Number 1	12. Was Dece Armed For rried 1 ☐ Yes If Yes Giv	dent Ever in Urces? 2012 No	J.S. 13.	Was Dece If Yes, spe			gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)		Race - Amer Black, White pecify: Whi	e, etc.
21215-0036	d within 72 ho piene. r than *natur r e Medical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 1 2	nt's Education est grade completed) College (1	-4or 5+)	life.	dent's Usu kind of wo DO NOT u	rk done d se retired)	uring mos	t of working			of Business/I	ndustry
Maryland 2	12 should be filed within hand Mental Hygiene. 7 Is marked other than "treumatic event, the Mer	To Be C	17. Father's Name (First, Middle Frederick E.						18. Mothe		First, Middle.		mame)	
_	t and 2 sho Health and tem 27 Is my		John F. Gannor  20a. Method of Disposition		20b.	3005	S. Le	isur	e Woı			ilver		g, MD 20906
Baltimore,	permil. Pages Department of I Importent: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( 21. Signature ofneral Service	Specity) Mausol	State	ate of H	eaven	Cemete	ery	2005			Sprin	ng, Maryland
ñ	Per Per Per Per Per Per Per Per Per Per		1 hobert	Lames	ey	5	00 Ur	iver	sity	Blvd,	W, Si	lver		g, MD 20901
8760,	Physician personned person	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	or as a consec	quence of):	tiz	Sy	nelm	me				Onset and Death
O. Box 6	certific rding p	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		inth 2 ☐ Feta ant at time of o	al déath 3[	⊒Ectopic p ⊒ Other (sp					23d	l. Date of delin	very Day Year
rds, P	es pe	by	Part II. Other significant condit	ions contributing to de	eath but not re	sulting in the u	inderlying o	ause give	n in Part I					the cause of death?
I Records,	The ate ha	Completed									24a. Was autop perfor	sy	th. Were aut prior to c death? 1 ☐ Yes	topsy findings available completion of cause of
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medic examiner?					0.1			Check only o			
of	ding Phys	atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pend 2 Accident inves	28a. Date		28b. Time of Injury		28c. Injury Work	at .? ∕es 2 □	28	a 5 □ Resid d. Describe h			ity)
Division	or Oir	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 288. Place	of Injury - At h		reet, factor	y, office		28	f. Location (S City or Tow		lumber or Ru	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the I Examiner: On the ba and mann	asis of examin	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my op	e, date an inion, dea	id place, an ith occurred	d due to the d at the time, d	ause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
	To the Hi within 24 To the Fu	Me	29b. Signature and title of certif	er			29	c. License	number			29d. Date s	igned (Month	n. Day, Year)
	6		Paul Ba 30. Name and address of perso Paul Andrew	·		m 23a) (Type,	Print)		0033. ip Dr			Nay o		20832
	Sta Registi		31. Date filed (Month, Day, Yea MAY 0		egistrar's Sign	1,000						cy	, 2	

				aryland / Depa	artment of Health and Natificate of Death	lental Hygie	-	16808
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  Edna Earl Harteni  4a. Facility Name (If not institution, give street and number)	s Gainey G	4b. City, Town, or Location of Death	2. Date of Death Month April 27	4c. County of Death	3. Time of Death 8:20 A. M
	Funeral Director		Holy Cross Hospita1  5. Social Security Number 246-50-5949  Usual Residence of Decedent  248 F 7. As	72 Yrs.	Silver Spring H Under 1 Year H Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You March 1,	Montgom 9. Birth Cou. 1933 Nort	place (State or Foreign ntry) h Carolina
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show eny injury or other treumatic event, the Modical Examitter must be multilised at once.	Director	10a. State 10b. County  District of Columbia  10e. Street and Number	10c. City, Town or Lo	hington  10f. Zip Code	10g.	Citizen of What Cou	10d. Inside City Limits 1  Yes 2  No
	eath with	eral D	922 - 44th Street, N. E.  11. Marital Status 12. Was Decedent	Ever in II S 13.1	20019		nited Stat	
9000	nours after d	d by Funeral	1 Never Married 2 Married 1 Yes, 2 M 3 Widowed 4 Divorced Year or Dates:	No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecity fes of No- Rican, etc.)	Black, White, Specify: B1a	etc.
21215-0036	d within 72 h giene. ir then "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th grade  College (1-4or the state of t	5+) //re.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) me Care Provider	ing 16t	Domesti	
Maryland	uld be file Mental Hyg rked othe rtic event,	To Be C	17. Father's Name (First, Middle, Last)  Erastus Gainey		Minnie	e (First, Middle, Mai Leak		
	I and 2 sho lealth and I om 27 is ma her treuma		Wilthric Earl Marshall (Da	sband) 19b. Mailir ughter) 40 20b. Place of Dispo	ng Address (Street and Number or Run 07 College Height	s Drive;Hy	attsville	,Maryland
Baltimore,	nit. Pages artment of hortent: If ite injury or of		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  21. Signature Funeral Solvice Licensee	Fort Lin	coln Cemetery May	3,2005 Bi		Maryland
B	permi Depa impo eny ir	y y	Xandaph & Ho	U	R. N. Horton Compa 600 Kennedy Stree	t,N.W.;Was	shington,D	.c. 20011
	Physician /Medical Examiner		resulting in death)	Encephalo a consequence of):		or respiratory arrest,		Approximate Interval Between Onset and Death
,092	ficate be executed physician and st the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of):				
.O. Box 68	The law requires that the death certifica ate has been signed by the attending phrpage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♠ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
rds, P.	w requires that been signed k should be deta	by	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause given in Part I.		co use contribute to the	
Division of Vital Records,	: The law re cate has be page 2 sho	Completed				24a. Was an autopsy performed	prior to cor	psy findings available inpletion of cause of
Z Z	Physicien: Th r this certificate ral director, paç	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatie	ent 2 ER/Outpatien		(Check only one)	6 Other (Facility	
sion of	ding Afte fune	ation: T	27. Manner of Death  1 Anatural 5 Pending 2 Accident investigation	ry 28b. Time of		28d. Describe how in		7)
DIVIS	by by	Certification;	4 Homicide building, et			City or Town, St	,	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best 2 Medicel Examiner: On the basis of and manner sta	examination and/or inv	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier		29c. License number <b>D-62571</b>	29d.	Date signed (Month, I	Day, Year)
	CP(6)	)	30. Name and address of person who completed cause of d Sarah Bromeland, M.D.; 15	eath (Item 23a) (Type,	Print) Holy Cross Hos Glen Road; Silver	pital Spring. M	aryland 20	0910
	Sta Registr			ar's Signature	E .			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRTL **Physician** 4:00 P M MEMNAR ROGER GRAYTON 30. 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner PRINCE GEORGE CHEVERLY MARYLAND PRINCE GEORGES HOSPITAL If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 6. Sex Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1₩ 2□F 64 March 28, 1941 Washington DC Director 578-54-2313 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ntai Hygiene. ed other than "natural", or ltams 23a or 28a-f show evant, the Medical Exametrior in bust be notified at 1XYes 2 No Directo CLINTON MARYLAND PRINCE GEORGE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20735 9006 Dangerfield Place death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. It important: If item 27 is marked other than "natural", or iter any injury or other traumatic evant, the Medical Experiment ODGS. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tisher Auto Automotive Care Technician 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fronie Perry Charles James Grayton, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20735 9006 Dangerfield Pl. Clinton, MD James Grayton/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 5-7-2005 Landover, Maryland Harmony Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Frazier's Funeral Home 21. Signature of Funeral Service Licensee 389 Rhode Island Ave. NW Wash., DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Drteviorelanote Candio Vascular **Physician** lan disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. the attending physician Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? detached for 4☐Pregnant at time of death 5 Other (specify) Yes 2 No P.0. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an encience 1 ☐ Yes 2 No in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) License number 29b. Signature and title of certifier なっか who completed cause of death (Item 23a) (Type, Print) DEVORE MD veensbong 203 Registrar's Signature-31. Date filed (Month, Day, Year) State 4 Registrar

			4 101	partment of Health and Meartificate of Death		2000	16910
40	*		Negistrar  1. Decedent's Name (First, Middle, Last)		Rag. I 2. Date of Death	No. () () ()	3. Time of Death
	Physici /Medio	al	Albert Lee Givens, Jr.		-	3 2005	2:00 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral	-	Holy Cross Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Silver Spring  (i) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montg	omery
	Director		577-60-8783 1™ 2□ F 57 Yrs.	Months Days Hours Min.	(Month, Day, Yes	ar) Count	ace (State or Foreign try) h., DC
	pu >		Usual Residence of Decedent				
	show	5	10a. State   10b. County   10c. City, Town or the Maryland   Montgomery	-ocation Burtonsvi	1110	10	od. Inside City Limits 1 ☑ Yes 2 ☐ No
	within 72 hours after death with the Maryland ene. than "netural", or itema 23a or 28a-f show the Medical Everilier mant be indiffed at	Director	10e. Street and Number	10f. Zip Code		Citizen of What Count	
	With 3a or	10		20866	10g.		
	death ma 2	Completed by Funeral	3659 Autumn Glen Circle  11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	offy Yes or No-	United  14. Race - America	an Indian,
9	after or Ite	Ē.	1 ☐ Never Married 2 ☐ Married   Armed Forces?  1 ☐ Syss 2 ☐ No If Yes, Give		lican, etc.)	Black, White, e	
003	ural',	d by	3 Wildowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: B	lack
15-	"natu	lete	(Specify only highest grade completed) (Giv	edent's Usual Occupation is kind of work done during most of working DO NOT use retired)	g 16b.	Kind of Business/Ind	ustry
12	withii ene. than	dwc	Elementary/Secondary (0-12) College (1-4or 5+)			D	
0 2	filed Hygi other	Be Co	12th 17. Father's Name (First, Middle, Last)	Clerk 18. Mother's Name	(First, Middle, Maid	Private en Sumame)	
lan	lid be fental rkad rlc ev	To B	Albert Lee Givens	I	Leila Gar	lington	
Maryland 21215-0036	and Na		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural			Code)
Σ	and 2 Belth n 27 i			9 Autumn Glen Circl	Le, Burton	nsville, M	D 20866
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelin and Mental Hygiene. Department of Heelin and Mental Hygiene. The mortant: If term 27 is marked other than "natural; or fterme 23e or 28e-1 show any injury or other traumatic event, the Medical Exercities must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, critical state in the state of Disposition cemetery, critical state in the state of Disposition cemetery, critical state of Disposition cemetery.	position (Name of Paratory or other place)	ite 20c.	Location - City or Tov	vn, State
Ë	Pag tment tant:		'4 □Donation 5 □Other (Specify)	Veterans Cem. 5/6/	2005	Cheltenha	m, MD
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licenses			neral Home	
		8. 0	23a. Part1. Enter the disease, or complications that caused the death. Do not en	4001 Benning Rd.,			
г	D		snock, prijeart failure. List only one cause on each line.		respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  Acute Myocard Due to (or as a consequence of):	ial Infarction			
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	ocutec nd Iransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events				
Ő,	ate be executed hysiclen and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed physicien and the burial-transit	dicai	d.				
9 X	The law requires that the death certification has been signed by the attending phage 2 should be detached for use as to	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			and Data of deliver	
Вох	atter I for u	cian	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
P.O.	that the de led by the a detached i	hysi	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown				
ς, σ	es thai igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the	cause of death?
ğ	w require been sig should b		Hypertension		1 🗆 Yes	2 □ No 3 □ Proba	bly 4 XUnknown
Division of Vital Record	e law re has be je 2 sho	Completed	Diabetes		24a. Was an autopsy	24b. Were autop	sy findings available pletion of cause of
<u>س</u>		Con			performed? 1 Yes 2 √1	death?	2 No
/ita	ilcian: Th certificete rector, paç	Be	25. Was case referred to medical examiner?	26. Place of Death	Check only one		
of	Physical direction	٦.	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			6 ☐Other (Specify)	
uo	I or Attending Physician: after death. Director: After this certifical in by the funeral director,	Certification;	27. Manner of Death  1 ☑Natural 5 ☐ Pending (Month, Day Year)  2 ☐ Accident investigation 22.	of 28c. Injury at 28 Work? M 1 ☐ Yes 2 ☐ No	d. Describe how in	Jury occurred	
<u>ISI</u>	Attendil death. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, s		Bf. Location (Street	and Number or Rural	Route Number.
2	Dir	erti	4 Homicide determined building, etc. (Specify)	,,	City or Town, Sta		
	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, an	d due to the cause	(s) and manner as sta	ted.
	To the Hos within 24 h To the Fur completely	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	d at the time, date a	nd place, and due to t	he cause(s)
	To the within 2 To the comple	Σ	29b. Signature and the of certifier	29c. License number	29d. [	Date signed (Month, D	
	5	,	1 Ster ( M)	D 24348		4.2	3.2005
R	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type				am 00011
	Sta	0	31. Date filed (Month, Day, Year)  2. Registrar's Signature	1500 Forest Glen R	d., Silve	er Spring,	MD 20910
	Registra		MAY 8 4 2005 Reduce & April	de			

	1	s Name (First, A	Middle, Las	st)							2. Date of D Month	eath Da	ау	Year	3. Time of Deat
dica nine:	. =	arles ame (If not insti	itution aive	street and n	umber)	Har		Town	or Location	of Death	April		200	5 ty of Death	7:51 a
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al		urity Number		ex M 2□F		yrs. last birthday	If Under Months		If Under	24 Hrs. Min.	8. Date of B	irth		ntgom 9. Birth	place (State or For
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	10a. State	ance of Deceder 10b. Co			10	c. City, Town or L	ocation								10d. Inside City Lim
Ş	Maryla	nd Mo	ntgom	nery		Silver S	pring								1 □ Yes <b>2</b> 🔀
Director	10e. Street a	nd Number					10f. Zip	Code				10g. Ci	itízen of	What Cou	intry?
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hv F		r Married 2 <b>존</b> wed 4□Divo		If Yes. G	ive Date <b>ei Q</b> ⊊	900 9 1064	1 ☐ Yes	2 <b>X</b> No	Specify:	:			Speci	ity: B	1ack
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		e of Funeral Ser		/		2	2. Name an	d Addre	ss of Facili	ity <b>Hi</b> i	es Rin	aldi	Fur	neral	Home
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	23a. Part1. I shock,	Enter the diseas or eart failure.	se, or comp	olications that	caused the	death. Do not er	ter the mod	e of dyin	ng, such as	cardiac	or respiratory	arrest,		1100	Approximate Interval Between
	Imiliadiale C disease or c														
4				a Myo	cardi	al Infar	ction								Onset and Death
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miner	Sequentially	list conditions, g to immediate r Underlying	{	b. <b>Hyp</b>	ercho	nsequence of):									Onset and Death
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Registrar

DHMH 17 Rev 1/2001

Physic /Medi		Decedent's Name (First, Middle, Last)     James Thomas Henman				2	2. Date of Deat Month 04	/ 2 <sup>Day</sup> / 20	05 <sup>ear</sup>	3. Time of Death
Exami		4a. Fecility Name (If not institution, give street and number) Atlantic General Hospital		4b. City, Town, o				Woi	ty of Death	er
Funeral Director		5. Social Security Number 217-12-4596  Usual Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. last	t birthday) _ Yrs.	If Under 1 Year Months Days	If Under 2	Min.	8. Date of Birth (Month, Day, 12 / 07 / 1	923	9. Birth	place (State or Foreigntry) MD
death with the Maryland ma 23a or 28a-f show Imust be notified at	tor		rlin	ation						10d. Inside City Limit
h with the 23a or 28	Funeral Director	10e. Street and Number 9350 Tall Timber Road		10f. Zip Code 21811			11	0g. Citizen o		ntry?
tours after dea	by	11. Marital Status  1 □ Never Married 2 M Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 X yes 2 □ No  If yes, Give Year or Dates: 1941		as Decedent of H Yes, specify Cub		n? (Spec Puerto Ri	ify Yes or No- ican, etc.)	BI	ace - Ameri ack, White ify: <b>Whi</b>	
l within 72 h liene. r then "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  8	16a. Decede (Give k life. D	ent's Usual Occup ind of work done O NOT use retire	pation during most of d)	of working	g	16b. Kind of		ndustry
Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Charles William Henman	<b>.</b>				First, Middle, A			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Manial Hygiene. Important: If item 27 is marked other than "natural; or itama 23a or 28a-f show Important: If item 27 is marked other than "natural; or itama 23a or 28a-f show impringing or other traumatic event, the Medical Eventhal must be notified at ance.		Doris Henman (wife)  20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	9350 se of Dispos etery, cremo rgree 22.	Tall Till tion (Name of atory or other pla  n Cemet Name and Addre  Willian	mber F	Road Da 7/02/ Bur	Berlin	, MD 20c. Location Berlin	21811 - City or T	own, State
eate be executed shysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cause of	fore of):	Schon	Cork	200	tescel	· does		ye_
that the death certifica ed by the attending pr detached for use as tt	by Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 9 Unknown	ath 3□6	ectopic pregnancy Other <i>(specify)</i> _	4	· · · · · · · · · · · · · · · · · · ·		l l	ate of delivionth	ery Day Year
The faw requires ate has been sign page 2 should be	e Completed by Pl	Part II. Other significant conditions contributing to death but not resulting  Chrone Lean Desar  Desart Capital Standard Communications  25. Was case referred to medical	and in the und	derlying cause give Clarke	the ste	inf tecis	1 Yes  24a. Was ar autopsy perform 1 Yes 2	s 2 No 1 24b.	3/1 Pret	he cause of death?  bably 4 Unknow  psy findings available  mpletion of cause of
afor Attending Physician: after death. Director: After this certific J in by the funeral director.	Certification: To B	examiner?    Yes   2   No	b. Time of Injury	28c. Injur Wor M 1 🗆	er: 4 □ Nurs	ing Home	Check only one  5 Resider  d. Describe hor	nce 6 Ot	rred	y) M Route Number,
To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use.	edical Certi	29a. Certifier (Check only  29 Medical Examiner: On the basis of examination	dge, death	occurred at the tir	me, date and ppinion, death	olace, an	d due to the ca		nanner as s	tated.
To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier  Pulse Science 29b. Signature and title of certifier	0	29c. Licens		20	29	od. Date sign	ed (Month,	Day, Year)
ET (d	/ te	30. Name and address of person who completed cause of death (Item 23:  31. Date filed (Month, Day, Year) 5 2005  32. Resistrar's Signature	(	Penir	sul	(	and.	roy.	Se 1	Ishey M.

			For State	State of M	aryland / Dep		Health and M	lental Hygi	iene	10011
	Di veriali		Registrar  1. Decedent's Name (First, Middle, I			rincate or	Dealli	2. Date of Death		3. Time of Death
	Physici /Medio	al	William A. I			45 ON T		May 2,	2005	12:15 M
	Examin	er	4a. Facility Name (If not institution, g Chesapeake Woods				or Location of Death ridge		4c. County of Dec	thester
	Funeral			. Sex 7. Ag	e (In yrs. last birthday,	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Sept.	9. B	irthplace (State or Foreign Jary Land
L,	Director		218-20-7646 Usual Residence of Decedent		76 Yrs.			sept.	19, 1940 1	aryrand
	f show	ō	10a. State 10b. County	a b = 10	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Ž	r 28a-	Directo	Maryland Dorche	ster	<u>Ca</u>	mbridge 10f. Zip Code		10	og. Citizen of What C	Country?
3	s 23s c	rai D	17 Buena Vista				1613		US	
36	be filed within 72 hours after death with the Maryland nat Hygiene. 9d other than "naturel", or ltems 23a or 28a-f show avent, the Medical Examination multiple at	by Funerai	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race · Arr Black, Wh Specify:	
5-0036	72 hou nature lical E	eted	15. Decedent's (Specify only highest of	Education	16a. Dece	edent's Usual Occu	pation during most of work	ina 1	16b. Kind of Busines	
2121	within ane. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retire Machini	ed)		Wire Cl	loth
<u>2</u>	m - 0 %	Be Co	17. Father's Name (First, Middle, La	st)			18. Mother's Name	e (First, Middle, N		
Maryland	nould be is Mental I narked o	To	Norman E. Hubba		401.44.11				Phillips	
	nd 2 st ulth and 27 is n r traun		19a. Informant's Name/Relationship Rose C. Hubbard,				tand Number or Run sta Ave.,			
altimore,	Pages 1 a nent of Hea nnt: If itam iry or othe		20a. Method of Disposition  1 Paurial 2 Cremation 3  4 Donation 5 Other (Spe	☐Removal from State	20b. Place of Dispo	osition (Name of matory or other pla	109)	Date 2	Cambridge	r Town, State
Baltii	permit Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic a <u>once.</u>		21. Signature of Funeral Service Lic		11201 3	2. Name and Address Urran-Br	ess of Facility Omwell Fur St., Cambi	neral Hor	ne,21613	, 110
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each li	the death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Septic	em/a a consequence of):					Onset and Death
	Examiner		Sequentially liet conditions	wrine		ct int	Ection			lucek
	led nsit	Examiner	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury	a /.	a-sunsequence of):	1 fail	ure			lweek _
60,	e be executed /sician and e burial-transit		that initiated events ' resulting in death) Last	c. <u>CNFON</u> Due to (or as	a consequence of):	7077	UPE			703 3
	icate b physic s the bu	dicai		d						
.O. Box (	To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the tuneral director, page 2 should be detached for use as the laws.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	sy		23d. Date of de Month	olivery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions Bladde	contributing to death b  CONCE	_	underlying cause gr	ven in Part I.			to the cause of death? Probably 4 □Unknown
Records,	ne law rec has bee ge 2 shou	Completed	cere brz	/ Vascui	lar acci	dent		24a. Was an autopsy perform	24b. Were a prior to death?	autopsy findings available completion of cause of
a	ysician: The is certificate hadirector, page	Be Co	25. Was case referred to medical				26. Place of Death		1 Ye	s 2 No
ot <	Physical this ce al direc	2	examiner? 1 Tes 2 No  27. Manner of Death		ent 2 ER/Outpatie	nt 3 DOA	and the second s		nce 6 Other (Sp.	ecify)
no	nding Phy th. :: After thi e tuneral c	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inju (Month, Da ion	ry Year) 28b. Time o Injury	Wo	iry at ork? ]Yes 2 □No	28d. Describe hov	w injury occurred	
Division of Vital	al or Attence atter death Diractor: d in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	ad 286. Place of In	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral completely filled	dicai	(Check only 2 Medicel Ex one)	Physicien: To the best eminer: On the basis o and manner st	f examination and/or in ated.	vestigation, in my	opinion, death occurr	ed at the time, da	te and place, and du	e to the cause(s)
	To the Mithing To the Comp	×	29b. Signature and title of certifier		, ,	29c. Licen	se number	29	od. Date signed (Mor.	nth, Day, Year)
			30. Name and address of person wh	o completed cause of	leath (Item 23a) (Type	Print)	0549 1	5	3/2/03	
_			Patricia J	o mson	100 R	3ramble	e St C	ambrio	age m	0
	Sta Registr	te ar	29b. Signature and title of certifier  30. Name and address of person when the second	5 2005 <sup>2. Reg</sup>	ar's Signature	Arred 5				

			1 _ Stete	epartment of Health and Modernificate of Death	lental Hygie	ne 2005	1 2 2 1 5
			Registrar  1. Decedent's Name (First, Middle, Last)	Dertificate of Death	Reg.	No.C. U U D	3. Time of Death
	Physici		Sandra Lee Hanson			2005 Day	6:00 PMM
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
	Exami	iei	Genesis HealthCare - The Pine			Talbo	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthe)	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	0.8:4	hplace (State or Foreign untry)
	Director		218-48-6457 1□M 2ÑF 57 Yr	s. Months Days Hours Min.	Dec. 20,1	947 Mary	untry) /land
1 -	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town of				
4	ehor	2					10d. Inside City Limits 14 Yes 2 □ No
7	28a-f	ect	Maryland Caroline Federa  10e. Street and Number		10-	0.00	
Q	with	Ö	405 Routzahn Lane	10f. Zip Code 21632		Citizen of What Co	untry?
X	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28s-f show re Medical Examitrer rust be ricitlified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.			USA 14. Race - Ame	ncan Indian
ပ	after or Ite	Fur	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No  If Yes, Give	13. Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
03	reli, c	l by	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify:	White
anson <b>21215-0036</b>	72 h	Completed	(Specify only highest grade completed) (0	ecedent's Usual Occupation Give kind of work done during most of work	ina 16b	. Kind of Business/l	industry
121	within ne. hen '	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired)			
	filed v Hygie ther f	ပိ	17. Father's Name (First, Middle, Last)	acker	First, Middle, Maid	Manufactu	ring
an	d be antal ced o	o Be	Elmer Clifton Adkins, Sr.		y Christin	,	
ndra Ha Maryland	Shoul nd Me mark	2		Mailing Address (Street and Number or Rura			in Code)
	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examitments use the right of all sonce.			O. Box 513, Sharpto			
Sa Baltimore,	s 1 a of Hea item		20a. Method of Disposition 20b. Place of D			. Location - City or	
E	Page nent c int: If		Tablilat 2 of sittation 3 of telloval from State	er Memorial Park 5/6/2	2005 Ca	mbridge,	Maryland
<u>a</u>	rmit spartn porte y inp		21. Signature of Funeral Service Lyangee	22. Name and Address of Facility Zeller Funeral Home			naryrana
_	8978		Fencie to felle	106 Main Street, Ea	st New Ma	rket, MD	21631
		9	26a. Part . Enter the disease, or comblications that caused the death. Do not speck, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac c	or respiratory arrest,		Approximate Interval Between
الم	Physician		Immediate Cause (Final disease or condition	helming			Onset and Death
~	/Medical Examiner		resulting in death)  Due to (or as a consequence of)		1.1		720
1		-	Sequentially list conditions, if any, leading to immediate b. Media State Us.	neer on left anterio	or Thorax		months
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury				
	axecu n and al-tra	Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence of)				years
760,	ate be executed nysician and he burial-transit	cai	d				
.89	uires that the death certificate signed by the attending phys d be detached for use as the						
ŏ	th cer endir	N/us	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of deli	very
Э.	e dea he att	Physician/Medi	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
Ρ.Ο	d by t	Phy	9 D Onknown				
S,	ires ti signe	by	Part II. Dther significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.			the cause of death?
Ö	law requir as been s 2 should	etec	Hupertension				
3ec	ne law has l ge 2 s	Completed	Hypersension		24a. Was an autopsy performed	prior to c	opsy findings available ompletion of cause of
<u>a</u>	i <b>ician:</b> The lav certificate has rector, page 2		OS Was and a state of the state		1 □ Yes 25€		2 No
₹	s certil	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		Check on one	0 FOTO (0	
<b>o</b>	g Phy er this eral o	n: To	27. Manner of Death 28a. Date of Injury 28b. Tim	tie of 28c. Injury at	me 5 Residence 28d. Describe how in		ify)
Ö	ath. r: Aft	atio	p⊠Natural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division of Vital Records, P.O. Box 68	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, St	and Number or Rui	ral Route Number,
Ω	ritel o						
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Medicai	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, d 2 Medicel Exeminer: On the basis of examination and/o	leath occurred at the time, date and place, a or investigation, in my opinion, death occurred	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month,	
			I Market only us	DZ5933		5.2.0	5
				PO. Print) CHMAN'S HANG	EASTON	, Ms	21801
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 4 2005  32. Registrar's Signature	forte		-	

John Hurley 05-02937 RPD

-029 )	937		1- StateUnpend Item 23	State of Maryland Ba&27 per me G8				•		•	16816
	Physic /Medi	cal	Decedent's Name (First, Middle, Last,  John Kenny H	) Murley				2. Date of Month Apri	Death 1 28,	2005 Year	3. Time of Death 0735 A M
	Examir	ner	4a. Facility Name (If not institution, give Easton Memorial Ho	ospital		Easton	r Location of Deat		r	c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Set 220–04–5338  Usual Residence of Decedent	x 7. Age (In yrs. las: 34	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Birth Day, Yea 25,	9. Bir 1970 M	thplace (State or Foreign ountry) aryland
3	with the Maryland a or 28a-f show Le notified at	tor	10a. State 10b. County MD Dorche	10c. City, 1	own or Lo	cation Hurlo	ck			· .	10d. Inside City Limits 1 Yes 2 No
3	with the	I Direc	10e. Street and Number 7004 East New Mark	rot Flyood Pd		10f. Zip Code	21643		10g. C	USA	ountry?
36	iges 1 and 2 should be filed within 72 hours after death with the Marylan in of Health and Mental Hygiene.  If itam 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic avant, if a Marileal Examiner must be notified at	by Funeral Director		12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 No If Yes, Give Year or Dates:	13.	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ▼ No	lispanic Origin? (S an, Mexican, Puer	Specify Yes or to Rican, etc.)	No-	14. Race - Ame Black, Whit	
215-00	within 72 hou ene. than "natura ne Mudical E	Completed	15. Decedent's Edu (Specify only highest grad			dent's Usual Occup kind of work done DO NOT use retired		rking		Kind of Business	•
Maryland 21215-0036	i 2 should be filed within in and Mental Hygiene. I is marked other than "Iraumatic avant, If e Mar	Be	10 17. Father's Name (First, Middle, Last)			delivery	18. Mother's Na		dle, Maide	·	tion
laryla	2 should and Mer is marke	2	Ronald K. Hurle	rpe, Print)		ng Address (Street	and Number or R		mber, City	or Town, State,	Zip Code)
	permit. Pages 1 and 2 Department of Health a Important: if itam 27 is any injury or other tra once.		Doris Hurley  20a. Method of Disposition	wife 20b. Plac		Box 26.  sition (Name of natory or other place)  sition (Name of place)		Oak, M		1662 Location - City or	Town, State
Baltimore,	iit. Page artment c ortant: ff injury or		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Sal	isbur	y Cremato	ory   5/2	2/05 Domas		lisbury, ral Home	
Ba	permit. Departr Imports any inji		I fair, lerr	~		00 Locust					
	Physician /Medical		23a. Part / Enter the disease, or complessor, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. In e cause on each line.  a. Dilated cardion Due to (or as a consequer	omyop		ig, such as cardia	c or respirator	y arrest,		Approximate Interval Between Onset and Death
	e be executed sciolar and sciolar and purial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent.  Due to (or as a consequent							
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal de 4 Pregnant at time of deat	ath 3	Ectopic pregnancy Other (specify)	,			23d. Date of de Month	ivery Day Year
rds, P	juires that n signed b uld be detz		Part II. Dther significant conditions con	ntributing to death but not resultin	ng in the u	nderlying cause giv	en in Part I.		id tobacco		the cause of death?
al Records,	: The law requir cate has been si , page 2 should l	Completed by						N PE	fas an utopsy enformed?	prior to death?	Itopsy findings available completion of cause of
of Vital	Physician: rthis certific ral director,	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient <b>次</b> 本ER	/Outpatien	t 3 DOA Oth	26. Place of De er: 4 ☐ Nursing F			6 ☐Other (Spe	cify)
o uoi	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.	atlon:	27. Manner of Death  1 Xetural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Descri	be how inj	ury occurred	
Division	To tha Hospital or Attending within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Locatio City or	n (Street a Town, Sta	and Number or Ru te)	ural Route Number,
	To tha Hospital or A within 24 hours after To tha Funaral Directompletely filled in by	Medical	29a. Certifier (Check only one)  1 Certifying Physical Examination (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death and/or in	occurred at the tirvestigation, in my o	ne, date and place pinion, death occu	a, and due to t urred at the tin	he cause( ne, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	1110		29c. Licens				il 29, 2	
			30. Name and address of person who co	ompleted cause of death (Item 23				imore.			
	Sta Registi	8	31. Date filed (Month, Day, Year)			food	,	- 7			

DHMH 17 Rev 1/2001

	t		1 - For State Registrar	State of Ma			t of H	ealth a	and M	ental Hyg	_	05	16817
1	Physici /Medi		1. Decedent's Name (First, Middle, La Anita Huff							2. Date of Deat April 2	9, Day 200		3. Time of Death 11:15a M
	Examir	er	4a. Facility Name (If not institution, girl Holy Cross Hos	oital	Un una la at hinta de	Si	.lve1	Spr:	ing	O. Data of Birth	4c. Count	gomer	•
	Funeral Director			Sex 7. Age 1□M 2☐xF	(In yrs. last birthda 69 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month Day, an. 29,	<sup>Year</sup> 936	Wash	place (State or Foreign lity)
	be filed within 72 hours after death with the Maryland nial Hygiene. So other than "netural", or Itema 23a or 28a-f show event, the Medical Examinar must be notified at	Funeral Director	10a. State 10b. County  D.C.  10e. Street and Number  3210 Banneker Dr  11. Marital Status  1 Never Married 2* Married	12. Was Decedent E Amed Forces? 1		ngton 10f. Zip	0018		gin? (Spe , Puerto F			What Cour	es Indian,
Maryland 21215-0036	e filed within 72 hours af al Hygiene. I other than "netural", or vent, the Medical Exem	Completed by	3   Widowed 4   Divorced  15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)  11 th  17. Father's Name (First, Middle, Las	If Yes, Give Year or Dates: ducation ade completed) College (1-4or 5-	16a. De	1□ Yes 2 cedent's Usua ive kind of wor b. DO NOT us nildcar	l Occupa k done d e retired,	ition furing most	er	g (First, Middle, M	Priva	te	
aryland	2 should be f and Mental t is marked of aumatic eve	To Be	Nathaniel Brown 19a. Informant's Name/Relationship	1	19b. Ma	ailing Address	(Street a	Alı	ma Re				Code)
iore, Ma	l and Health om 27 her tr		Carl Huff / Hus 20a. Method of Disposition 1% Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Dis	position (Namerematory or of		9)	Da		20c. Location	City or To	
Baltimore,	permit. Pages 'Department of h Importent: If ite any injury or of		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		Ft. L.	Incoln  22. Name and Alexan 5538 M	d Addres der larIb			uneral Forestv	Brentw Homes,		
>	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or conshock, or leart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to minisdiate cause. Enter Underlying Cause (Disease or injury	Bue to (or as a Septice	remia	enter the mode	of dying	g, such as	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
68760,	ficate be executed g physician and ts the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.	tic Cance consequence of):	er							
.O. Box	at the death certifica by the attending phitached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Fetal death	3 □Ectopic pre 5 □ Other (spe						ite of delive onth	nry Day Year
Records, P.	The law requires that the tte has been signed by thogge 2 should be detache	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying ca	iuse give	n in Part I.			acco use cont		e cause of death?
al Rec		Completed								24a. Was an autopsy perform	ed?	Were autor prior to con death? 1 □ Yes	osy findings available npletion of cause of 2 No
ion of Vital	ding Phys	ertification: To Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 □ Pending 2 □ Accident investigation	Hospital: 1 Inpatier  28a. Date of Injun (Month, Day)	28b. Time	of 28	Bc. Injury Work	r: 4 □ Nui at	rsing Hom	(Check only one	nce 6 □Oth		)
Division	To the Hospital or Attend within 24 hours effer death To the Funeral Director; completely filled in by the	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rule City or Town, State)								er or Rura	l Route Number,		
	To the Hospital or Al within 24 hours efter of To the Funeral Direc completely filled in by	Medical	one)	nysicien: To the best o miner: On the basis of and manner stat	my knowledge, de examination and/or d.				d place, au th occurre				
)	To the within To the comple	)	29b. Signature and title of certifier  Factoria  20 Name and address of across the	) Sall	(to = 22 ) T		D006	number 51768			d. Date signe		-
	THE .		30. Name and address of person who  Fabienne J. S.  31. Date filed (Month, Day, Year)	antel, M.D.	1500 Fo	rest G1	en I	Rd. S	ilveı	Spring	, Md.	20901	
	Sta Registr		MAY 0 5 200	5 Stewn	's Signature	and							

			1 - For Stete Registrer	State of Mar	-	artmen ertificate			and M		Reg. No.	00	5	16818
	Physici /Medic	al	Decedent's Name (First, Middle, Last)     Glenn H.      4a. Facility Name (If not institution, give seems)	Hunter		4b City	Town or	Location o	of Death	2. Date of De Month May	Day 1,	200 County of D	ž 5	3. Time of Death
	Examir Funeral	ier	Southern Marylan  5. Social Security Number   6. Seg	nd Hospita	(In yrs. last birthda)	C1:	into:		24 Hrs.	8. Date of Bir August	Pr	ince	Geor	e (State or Foreign
	Director		578-42-9170  Usual Residence of Decedent  10a. State 10b. County		Yrs.	1				August	14,	1935		h Carolin
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic event, the Medical Examinal must be notified at once.	To Be Completed by Funeral Director	Virgina Spottsyl  10e. Street and Number  6812 Estate Lane	vania  12. Was Decedent Ev Armed Forces?  1	er in U.S. 13  16a. Dec (Giv (Jiv))  19b. Mai 6812  20b. Place of Discometery, cr. Maryland	Lksburg  10f. Zip  224  Was Deced If Yes, spec  1 Yes 2  edent's Usua e kind of wor DO NOT us  Drive  Ling Address  Estat  position (Name	A O T lent of His ify Cubar 2 No II Occupa & done of eretired)  Control (Street a Ce La of the place of the p	Specify:  Ition Uning most  18. Mothe  Ma:  Ma:  And Number  ane;  Cem. 1	er's Name ry R er or Rura Fred  May 6	uth Gyg al Route Numbericksb pate 5,2005 ope Fun 538 Mar	Unit  16b. Kin  Priv  Maiden S  3  20c. Loc  Laur  Laur  Laur  Laur	VA. ation City e1, M Homes	Country/ates merican in/hite, etc. Black sss/Industrian 2240 or Town, D	1 ⊠ Yes 2 □ No ? Indian, ck try
8760,	death certificate be executed  We attending physician and e attending physician and but for use as the butial-transit	Physician/Medical Examiner	23a. Part1. Enter the disease on complishock, or heart faffure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a control of the contr	$\Lambda$	The mode	e of dying					MD.	Ap Int	N747 pproximate perval Between nset and Death
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rds, P.O	The law requires that the tee has been signed by the bage 2 should be detache	by	Part II. Other significant conditions cor	ntributing to death but	not resulting in the	underlying ca	ause give	n in Part I.				e contribute		ause of death?
Vital Records,		Completed								24a. Was autop perfo 1 🗆 Yes	an osy rmed? 2 A No	24b. Were prior to death	o comple	findings available etion of cause of No
Ħ	siciar certif irecto	o Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{Yes} \) 1	lospital:	2 A ER/Outpatio	nt 200	Othe	-		(Check only o				
Division of	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day )	28b. Time		Bc. Injury Work	INUI	2	ne 5 Resid 28d. Describe h			рөсіту)	
Divis	tal or Attences after death all Director: ed in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.		treet, factory	, office		4	28f. Location (5 City or Tov		Number or	Rural Ro	oute Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	sicien: To the best of ner: On the basis of ea and manner state	xamination and/or i	nvestigation,	at the tim- in my op	e, date and inion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) a date and p	nd manner lace, and d	as stated lue to the	d. e cause(s)
	To To con	X	29b. Signature and title of certifler			290	License DO E	number 0590	428		29d. Date	signed (Mo	onth, Day,	, Year)
1	(3)			clester	750	Print)	Su	rrut	4	Rd	Clin	ta,	M.0	2073
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 2005	3 Registrar	s signature	also .						,		

		1 - State Registrar  1. Decedent's Name (First, Middle, Las			artment of Health and Martificate of Death	Reg. N	6UU5	1 6 8 1 S
Physici /Medic Examin	al	Stephen E. Haran  4a. Facility Name (If not institution, give  401 First Street			4b. City, Town, or Location of Death  Chesapeake City  If Under 1 Year   If Under 24 Hrs.	May	7 Year 7 2005 4c. County of Death	06:40
Funeral Director		5. Social Security Number 073-40-5920  Usual Residence of Decedent	XM 2FF	55 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea ugust 10,		ace (State or Foreigr ry) <b>York</b>
the Maryland 28e-f show	Director	10a. State 10b. County  New York Nassau  10e. Street and Number		ity, Town or Lo aldwin	cation 10f. Zip Code	109.0	10 Citizen of What Count	d. Inside City Limits 1 ☐ Yes 2 No
filed within 72 hours after death with the Maryland Hygiene. uther then "neturel", or items 23e or 28e-f show ant, the Madical Examiner must be neithed at	by Funerai	19 Walnut Street  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1   Yes   2 1 No If Yes, Give Year or Dates:	'	11510  Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	U1 ecify Yes or No-	nited Stat  14. Race - America Black, White, e	<b>es</b> In Indian, tc.
ithin 72 ho ne. nen "netur	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Inde	ustry
e d a	To Be Cor	12 17. Father's Name (First, Middle, Last) Michael J. Hara		Gener		e (First, Middle, Maid ne Byrne	Constructi en Sumame)	on
1 and 2 should I Health and Meni Iem 27 is marke other treumatic	-	19a. Informant's Name/Relationship ( Mary Ann Haran/wi	Type, Print) <b>fe</b>	19 Wa	ng Address (Street and Number or Rulling Street, Bald	al Route Number, Cit	York 11510	
permit. Pages 1 a Department of Hes Importent; if item any injury or othe		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Dispo cemetery, crer Ly Rood	sition (Name of natory or other place)	, 2005 Wes	Location - City or Tov	Jersey
that the death certificate be executed  Washington  The death of the attending physician and detached for use as the buriat-transit	dicai Examiner	23a. P. 1. Enter the diselse, or composition of the control of the	b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	quence of):	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death  Mym Wist
the death certiffic the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
quires that th n signed by I uld be detach	by	Part II. Other significant conditions of	contributing to death but not re	sulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	a cause of death?  bly 4 Unknown
The law requires that the ale has been signed by the page 2 should be detache	Completed					24a. Was an autopsy performed	? prior to com death?	sy findings available pletion of cause of
0 -	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	nt 3 DOA Other: 4 Nursing H	th (Check only one) ome 5  Residence 28d. Describe how in		8 ed & Breek
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ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland		nt of Health and M te of Death		iene <sub>eg. No</sub> ? 0 () 5	16820
	Physici	an	1. Decedent's Name (First, Middle, Last		. l k		2. Date of Deat Month	Day Year	3. Time of Death 0843 M
	/Medio		4a. Facility Name (If not institution, give		Stock 4b. City	, Town, or Location of Death	3	0/ 2005 4c. County of Dea	
	Funeral Director	Ç.	Peninsula Legional 5. Social Security Number 6. Se	redical cen	ter 5	Palisbury r 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Wilcomic Year) 9. Bir	
	pu s		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Location				10d. Inside City Limits
	f sho	jo			ncotcagu				1 XYes 2 □ No
	r 28a-	Director	VH HCCOMO	(CI)   CIII		p Code	1	0g. Citizen of What Co	ountry?
	th with		3042 Main St	reet		3336		U.S.A.	
98	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 27 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	i. 13. Was Dece If Yes, spe 1 ☐ Yes	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
9-0	2 hou	ted I	15. Decedent's Edu	cation	16a. Decedent's Usu	ual Occupation	ina	16b. Kind of Business	
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	ss 1 and 2 sho of Health and item 27 Is mu other trauma		19a. Informant's Name/Relationship of Uniting Hands	ock/Husband	20112 00	s (Street and Number or Rur aîn Street (	hincole	City or rown, State,	33334
nor	0 0 = 2		1 ☐ Burial 2 ☑ Cremation 3 ☐ B  '4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	metery, crematory or	other place)		h	A
Baltimore,	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licens  Amanda C	99	22. Name a	nd Address of Facility		7 Church S	
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	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	Oral - Da	2		
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	apte of):	- 10 mysse			
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Vital		Be C	25. Was case referred to medical examiner?			26. Place of Deat			
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	Dhyciai	200	1. Decedent's Name (First, Middle, La	nst)						2	Date of Deat	h Day	Year	3. Time	e of Death
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	Funeral Director			5ex 7. A 1∭ M 2□ F	88 	last birthday) Yrs.	Months	Days	Hours	Min.	Date of Birth (Month, Day, ane 14,	Year) 191		place (Sta intry) SS <b>i</b> SS	te or Foreign
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation			-				10d. Inside	City Limits
	be filed within 72 hours after death with the Maryland tal Hygiene. sd other than "natural" or Itams 23a or 28a-f ahow evant, the Medical Eraniner must be routiled at	ctor	Maryland Prince	George's				Mito	chell	ville				1 <b>)</b> Y	'es 2 □ No
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0	[4]		30. Name and address of person who												
			Alain G. (				14 01	.d Ma	rlbo	ro Pik	ce, Upp	er Ma	ar1boro	, MD	20772
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 8 4 200		rar's Signa	ture	12								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** HENRY 12:61 A M APRIL LUCILLE 3005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🙀 F 95 Yrs. Director October 1 1909 Maryland 579-12-5496 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-f show other traumatic event, the Madical Examiner must be notified at 1 X Yes 2 ☐ No Director MD Lanham Prince George's 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 4501 Crandall Court 20706 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. ☐Yes 2 No fYes, Give 1 Never Married 2 Married 1 ☐ Yes 2x No Specify: þ 3 ₩Widowed 4 Divorced If Yes, Give Year or Dates: 21215-003 "neturel" **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Home Maker Private 11th17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be John Banks Nettie Smith ೭ Department of Health and Important: If item 27 is many injury or Attention 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1448 Congress Place S.E. Washington, DC 20020 Helen Plater/Daughter altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Arbutus Park 5/6/05 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that have leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prote Physician disease or condition resulting in death) DAGG /Medical Due to (or as a consequence of): Examiner or a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examine certificate be executed burial-transit Due to (or as a onsequence of) Box 68760, physicien Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) the Ö à ئ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2010 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has 200 No 2 No 1 Yes 1 TYes of Vital director 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 patient Other: 1 Tyes 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: Division or Attending Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) MBS 31069 3/05

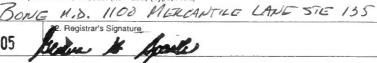
CP ()
State

31. Date filed (Month, Day, Year)

MAY 0 4 2005

11-

6 EORGE



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

LARGO MD

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 1 - For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $01^{\text{Day}}$ **Physician** 2005 HUNTER BLAKE TRE VON May 20:46 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly 6. Sex 1 1 M 2 I F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 0 - 2 5 - 1 9 8 6 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months | Days Hours VIRGINIA 18 227-39-0039 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r then "neturel", or Items 23e or 28e-f ehov The Madical Examiner must be notified at 1 Yes 2 □ No Director WASHINGTON DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20020 1905 FAIRLAWN AVENUE, SE Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 No Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 1 2 t h College (1-4or 5+) EDUCATION STUDENT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked othe any injury or other treumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HUNTER, JR. SANDRA GAIL JONES CLEMMIE LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1905 FAIRLAWN AVENUE, SE WASHINGTON, DC SANDRA G. HUNTER - MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEMETERY 5-07-2005 SUITLAND MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TAYLOR'S FUNERAL HOME 21. Signature of Fuperal Service Licensee 1722 NORTH CAPITOL ST., NW WASH.DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one eadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple sunshot pounds Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertain Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No 24a. Was an autopsy performed? certificate ! 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospitel or Attending Subject 5 Pending investigation 1 Natural was 1 ☐ Yes 2 No death. 5-1-05 20:00 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 5028 Benning ( SE Washin fon Director: 6 ☐ Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after vehille 14 a within 24 hours a To the Funerel D motor 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 🐒 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 02, 2005 min OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LI LING 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 0 4 2005 Registrar

			For State Registrar	State of Maryla	•			Mental Hygie	ene .No.2005	16001
	Physici		Decedent's Name (First, Middle, La.  Norman	Jackson				2. Date of Death Month April 27	Day Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give 3 をみし らい こっぷ	e street and number)		Swit			4c. County of Death	eorgis
	Funeral Director		5. Social Security Number 578-40-6945 t.  Usual Residence of Decedent	EM 2□F	s. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Sept. 22,	ear) 9. Birth Cou 1931 Wash	place (State or Foreign ntry) lington, D.C
	e Maryland Ba-f show Illfied at	ctor	10a. State 10b. County  MarylandPrince G		City, Town or Lo					10d. Inside City Limits 1 ⊈Yes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours etter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show important: If item 27 is marked other than "natural", or Items 23e or 28e-f show appring or other treumetic event. I'te Medical Example must be natified at once.	Completed by Funeral Director	10e. Street and Number  3821 Swann Rd.  11. Marital Status	12. Was Decedent Ever in	U.S.   13.	10f. Zip Code  207  Was Decedent of Hi If Yes, specify Cuba			United St	ates
9000	nours efter oural, or Itel	d by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 → Yes 2 → No 11 If Yes, Give Year or Dates: 6/4	/8/1950 /1954	1 ☐ Yes 2 ☐ No	Specify:			ack
21215-0036	d within 72 this piene. It than "nate the Medica	omplete	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired .nsporter	during most of work	ing 16	b. Kind of Business/Ir	,
Maryland 2	should be filed nd Mental Hygie marked other imetic event, the	To Be C	17. Father's Name (First, Middle, Last) Unknown				Mary			
	1 and 2 sho 1ealth and 1m 27 Is mu ther treum		19a. Informant's Name/Relationship (  Delores Jackso  20a. Method of Disposition	n / Wife	3821	Swann Rd.	Suitlan	d, Md. 2	ity or Town, State, Zij 0746 c. Location - City or T	
Baltimore,	permit. Pages Department of I Important: If ite any injury or of once.		1 Burial 2 Cremation 3 C  4 Donation 5 Dother (Specification 2). Signature of Funeral Service Lice	W	ashingt	osition (Name of matory or other place on Nation 2. Name and Address	a1 5/7/	2005	Suitland,	Md.
Ba	permi Depa Impo any ii		23a. Part1. Enter the disease, or comshock, or heart failupe. List only	ane 210108	-	Alexander 5538 Mari	boro Pik		Homes, P.A	20747 Approximate Interval Between
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8760,	ate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, loading to knin ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Tua to (or as a cons c. Due to (or as a cons d.						
P.O. Box 68	death certific e attending p od for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fr 4 □ Pregnant at time o 9 □ Unknown	etal death 3	⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>			23d. Date of deliv Month	ery Day Year
	The law requires that the tipe has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	inderlying cause give	en in Part I.		cco use contribute to t	he cause of death?
i Records,		Completed						24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
Division of Vital	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Year,	t home, farm, sti	of 28c. Injury Work M 1 []	er: 4 🗆 Nursing Ho	28d. Describe how	et and Number or Run	
۵	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical Cert		ysician: To the best of my kinner: On the basis of exam and manner stated.	nowledge, deat	h occurred at the tim	ne, date and place, pinion, death occur	and due to the caus	se(s) and manner as s	stated. o the cause(s)
•	To the Ho within 24 To the Fu	Mec	29b. Signature and title of certifier	plate 30		29c. License	o number	29d	Date signed (Month,	Day, Year)
(	16/1	9	011	er 3001 180	spital	Drint)		y Morry	land	
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 9 5 200	32. Registrar's Sig	gnature F Apa	de		,		

:PM 5-03054 :onna Johnson-Bunch

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			Decedent's Name (First, Middle, L.	ast)				2. Date of Deat	h		3. Time of D	Death
	Physici /Medic		Donna Lee	Joh	nson-Bunch			Month May	$02^{\text{Day}}$ , $20^{\text{N}}$	05 2	20:33	М
	Examin		4a. Facility Name (If not institution, gi		ber)	· ·	or Location of Death	h	4c. County of		_	
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	Funeral Director			Sex 7 1 □ M 2 XXF	. Age (In yrs. last birtho 48 Yr	Months Days		(Month Day	Year) 27, 1957	Birthpla Country	ce (State or y) ngton.	Foreign
	- 70		Usual Residence of Decedent					redically 2	27, 1227	wasim	iguon,	<u></u>
	show	<u>.</u>	10a. State 10b. County		10c. City, Town o	or Location				100	d. Inside City	
	8e-f	octo	Maryland Prince Geo	orge's	Templ	e Hills					1 Tes	XXX/0
	with t	Funeral Director	10e. Street and Number 3350 Curtis Drive			10f. Zip Code 207	V.O	1	0g. Citizen of Wh	at Country	y?	
	ns 23	era	11, Marital Status	12. Was Deced	lent Ever in U.S.	13. Was Decedent of		pecify Yes or No-	USA 14. Race -	American	n Indian	
ထ	or fler	F	1 ☐ Never Married 2 ☐ Married	Armed Ford	es? XIX No	If Yes, specify Cu	ban, Mexican, Puert	o Rican, etc.)		White, et	c.	
21215-0036	72 hours after death with the Maryland neturel; or flems 23e or 28e-f show Jical Examinat must be motified at	1 by	3 ☐ Widowed 4 ☑ Pivorced	If Yes, Give Year or Dat	es:	1 ☐ Yes 2 ☑ No	Specify:		Specify:	Blac	ck	
5-(	"netu	Completed	15. Decedent's E (Specify only highest g		(0	ecedent's Usual Occu	during most of wor	rking	16b, Kind of Busi	ness/indu	stry	
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9	filed with Hygiene. other ther		17. Father's Name (First, Middle, Las		- RAILLI	ISCIALIVE NO	1	me (First, Middle, M			urrege	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene Item 27 Is marked other then "neturel", or flems 23e or 28e-f show other treumatic event, the Medical Francian fount be notified at	To Be	Elbridge J.Johns	son			Claude	tte Raiford	ì			
ary	and N		19a. Informant's Name/Relationship	(Type, Print)	19b. N	Mailing Address (Stree	at and Number or Ru	ıral Route Number,	City or Town, St	ate, Zip C	ode)	
	item 27 l		Donise Gordon / Daug	hter		Hillmar Dri	ve #407 For	restville.	Maryland	20747	7	
ore	0 0		20a. Method of Disposition 1 □ Burial 2 ▼ remation 3	□Removal from S	tate cemetery,	isposition (Name of crematory or other pl	1	1	20c. Location - Ci			
Baltimore,			4 □ Donation 5 □ Other (Spec	ify)	Kalas Cre	-	May 5	5,2005 E	dgewater,	Mary1	and	
Bal	permit. Departn Importe eny inju		21. Signature Funeral Service Lice	onses		22. Name and Addi	ess of Facility Geo Hill Road O	orge P. Kal		1 Home 20745		
			23a. Part1 Enter the disease, or cor shock, or heart failure. List only	nplications that car	used the death. Do no					A	Approximate Interval Between	/een
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9 ×	ertific ding p	/Mec	IF FEMALE:	020 15 100 0100						!		
Вох	death certifi e attending p d for use as	lan	23b. Was decedent pregnant in the past 12 months?	1 Live bir	ome of pregnancy th 2 Fetal death	3 Ectopic pregnan	су		23d. Date of Month			ear
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ecords,	w requires been sign should be			· · · · · · · · · · · · · · · · · · ·				1 □ Ye	s 2 No 3	☐ Probab	oiy 4 🗆 Un	ıknown
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Vital	Physician: The this certificate al director, pag	Be (	25. Was case referred to medical examiner?					ath (Check only one		,		
of \	shys this	ပ္	1X Yes 2 No 27, Manner of Death		patient XXER/Outp	allent 3 DOA		lome 5 Reside				
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	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical C	29a. Certifier 1 Certifying P	miner: On the bas	pest of my knowledge, on stated	death occurred at the or investigation, in my	time, date and place opinion, death occu	e, and due to the ca	tuse(s) and mannate and place, and	er as stated due to the	ed. 2 cause(s)	47
	To the within 2. To the complet	Mec	29b. Signature and title of certifier	and manne	or stated.		ise number		9d. Date signed (			
	- 5 - 5		XO LKLO	111	)	OCM	Œ		May 03,			
P	(3)		30. Name and address of person who	completed cause	of death (Item 23a) (T	/pe, Print)	Character !	D-1:		1 .	0400	4
1	0		31. Date filed (Month, Day, Year)		ojetrarie Signatura		n Street	Baltimo	re, Mary	Land	21201	1
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			1 For State	State of Maryland		artment of H			9	005	10000
		4	Registrer  1. Decedent's Name (First, Middle, Last)	)	061	tillicate of t	Jean	2. Date of De	Reg. No.	000	3. Time of Death
	Physicia	an	NANCY JEFFRESS	,				Month APRIL	Day 29,	Year 2005	
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea			ounty of Death	9:30P
	Examin	lęr	6404 MANOR CIRCLE				INTON			RINCE G	FORCES
	Funeral		5. Social Security Number 6. Sec	x 7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days					place (State or Foreign
	Director		001 42 7559	□M XIX F 54	Yrs.	Months Days	Hours War	JUNE 20			HAMPSHIRE
Т	pur *		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	laryla sho	ō	,								XiX Yes 2 No
	the A	Director	MARYLAND PRINCE GE	CORGES   CL1.	NTON	10f. Zip Code			10g. Citize	n of What Cou	ntry?
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	ma 2	Funerai		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H				. Race - Americ	can Indian,
٥	after or Ite		1 Never Married 2 Married	1 □ Yes XX No If Yes, Give		ii Tes, speciily cubs 1 □ Yes ※X No	Specify:	no mean, etc.)		Black, White,	
215-0036	hours after tural", or Ite	d by	3 Widowed 4 Divorced	Year or Dates:						pecify: WHI	
7	"nati	Completed	15. Decedent's Edu (Specify only highest grad	ucation le co <i>mpleted)</i>	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking	16b. Kind	of Business/In	dustry
7	within 72 ene. then "nai	g .	Elementary/Secondary (0-12)	College (1-4or 5+)		ACCOUNTAI				PRIVAT	Ŧ
מ	be filed within 72 hours after death with the Marylan ital Hygliene. Id other than "natural", or liema 23s or 28a-1 show other than "matural", or liema 23s or 28a-1 show event. The Marylaul Examples must be notified at	Be Co	17. Father's Name (First, Middle, Last)			HOOOUNIA		me (First, Middle	, Maiden Su		
yland	fental rked c	To B	WINSTON M. EDWARDS	5			DOROT	HY SPAUL	DING		
Mary	and A		19a. Informant's Name/Relationship (Ty	ype, Print)	19b. Mailir	ng Address (Street	and Number or F	lural Route Numb	er, City or T	own, State, Zip	Code)
	s 1 and 2 should f Health and Men item 27 Is marke other traumatic			EX-HUSBAND	_	MANOR CI	RCLE DRI	4		MD 207	
ore	Pages 1 nent of H int: If ite		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐ F		ace of Dispo emetery, crei	osition (Name of matory or other place	· I	Date	20c. Loca	tion - City or To	own, State
Baitimore,	t. Pa rtmen rtent: njury		`4 ☐ Donation 5 ☐ Other (Specify)	IKLID		ION CEME		05/2005			IARYALND
Ra	permit. Pages Department of Importent: If it any injury or o	4	21. Signature of Funeral Service Licens	shell	M	2. Name and Addre IARSHALL S 308 SUITI	FUNERA	L HOME O	F MAR	YLAND, I MD 207	NC.
			23a. Part I. Enter the disease, or compleshock or heart failure. List only of	lications that caused the death							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a OVARIAN CAN	ICER						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
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× 68	ertifica ling ph e as th	Physician/Med	IF FEMALE:	00-16							
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oj.		ysic	1 ☐ Yes XX No 9 ☐ Unknown	9 Unknown	34.II 3L						
J.	th de de	by Ph	Part II. Other significant conditions co	ntributing to death but not resu	alting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
rds	w requires been sign should be							10	Yes XX	No 3 ☐ Prot	oably 4 Unknown
Records,	law re	Completed						24a. Was		24b. Were auto	opsy findings available impletion of cause of
		E O						perfo 1 ☐ Yes	ormed?	death?	2 □ No
/Ita	icien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	11		24		ath (Check only			
of Vital	this al dii	10	1 Yes XX No  27. Manner of Death		ER/Outpatier			Home XX Res			(y)
	arte Arte une	tion	XX Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2 □ No	2000		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	of or Attending after death. Director: After d in by the fune	fica	3 Suicide 6 Could not be	288. Flace of Injury - At Ho	me, farm, st	reet, factory, office				Number or Rura	al Route Number,
	s afte	Certification:	4 Homicide determined	building, etc. (Specify	/)			City or To	WII, State)		
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical		vsician: To the best of my kno iner: On the basis of examina and manner stated.							
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)
			1	eron		D29	142		MAY	Y 03, 2	005
2	(10)		30. Name and address of person who co			Print)					
_			CHARLES BOICE, M.			EORGIA AV	E., SUI	TE 205 S	ILVER	SPRING	, MD 20902
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 0 4 2005	2. Registrar's Signa		les .					

		1	For State Registrar	State of M	aryland	-	rtment of tificate of	Health and Death		giene	005	16827
		1	. Decedent's Name (First, Middle, Las	t)					2. Date of Dea	ith Day	Year	3. Time of Death
	sicia	_	Connie	E. Ke	ys				Month	Jay	2005	6:00 PM
	ledica imine		a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Dea	th	4c. Co	ounty of Death	
			Calvert Manor Hea	lthcare Ce	enter		Ris	ing Sun		Ced	cil	
Fune	eral		Social Security Number 6, St		e (In yrs. la		If Under 1 Year Months Days		. (Month, Day	/, Year)		lace (State or Foreign try)
Direc	tor		207-16-1270		89	Yrs.			5-30-1	915	Ashe	Co. NC
pug *	_	-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				1:	0d. Inside City Limits
sho	8 0 E	.	MD Cecil		R.	ising	Sun					1 ☐ Yes 2 ☐ No
the N		ec -	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Coun	itry?
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leath	970	Funeral Director	1. Marital Status	12. Was Decedent	Ever in U.S	i. 13. \		Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No		Race - Americ	
fter c		틸	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀					no Hican, etc.)		Black, White,	atc.
O30	T.	5	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 2∏ No	o Specify:		3/	рес <i>ify:</i> Wh	nite
5-0 72 hc	2	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	lent's Usual Occi kind of work don	e durina most of wo	orking	16b. Kind	of Business/Inc	dustry
Z igh	N N	ğ	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retir	red)		П.	- 3	
Ind 21215-0036  be filed within 72 hours after death with the Maryland tla! Hygiene. Indition "natural", or Itams 23a or 28a-f show	H H		Unk •			Canne	er	18 Mother's Na	ame (First, Middle,		ood	
da a	ava	മ്	Frank Phi						lie Eldr		,	
arylan 2 should be and Mental Is marked	natic	P	19a. Informant's Name/Relationship (	-	_	19h Mailir	ng Address (Stree	et and Number or F			own, State, Zip	(Code)
Mal d 2 st th and 7 ls r	traur	- 1	Elsie Donne		daugh			ltimore F				
e, M 1 and 2 Health am 27	ther	-	20a. Method of Disposition	ty GLUIO			sition (Name of natory or other pi		Date		tion - City or To	
Pages nent of l	0 0		1 Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify			,		l l	2005	0	ord, PA	10262
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If Itam 27 Is marke	in in	4	21. Signature a ray Service Licer	21	, J	Lord C	Cemetery  Name and Add	and a Complete.				
Balti Permit. Departm Imports	any ir		MUNIA	SHIM		9.6	Dina S	t. Oxford			.ins run	neral Home, Inc.
		Ť	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	the death.							Approximate Interval Between
Pnysic	iso .		Immediate Cause (Final	DEME		D1 21	OMEN -	TVOS				Onset and Death
/Medi	ical		disease or condition resulting in death)	aue to (or a			Cir joid	1170				
Exami	ner		Sequentially list conditions	b								
P	#	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to (or a	s a consequ	ence of):						
and brus	-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequ	ence of):						
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687 tificate g physi	the		2	_ d								
	Se as	Physician/Med	IF FEMALE:	23c. If yes, outcom						23	d. Date of delive	ery
Box eath cer	for n	clar	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	1 ☐Live birth 4 ☐Pregnant a			⊒Ectopic pregnar ⊒ Other (s <i>pecify)</i>				Month	Day Year
. 0 0	detached for	lys	9 Unknown	9□ Unknown								
	p det	by P	Part II, Other significant conditions	contributing to death	but not resu	ılting in the u	nderlying cause	given in Part I.	23e. Did t	obacco use	e contribute to t	he cause of death?
cords w requires been sig	d blu		TYPHRITENSION						. 1 🗆	Yes 2 💢	No 3 ☐ Prot	oably 4 Unknown
10 > 0	2 sho	Completed	Consilory Anthi	Y DISTASE					24a. Was		24b. Were auto	opsy findings available impletion of cause of
Rec The tav		HO								rmed?	death? 1 ☐ Yes	
Vital F ician: Th certificate	tor, p	O	25. Was case referred to medical					26. Place of D	eath (Check only	one)		
(3	5	To B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 Inpai	ient 2 🗆 I	ER/Outpatie	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Resi	dence 6	Other (Specia	(y)
	funeral		27. Manner of Death  S ☐ Pending	28a. Date of In (Month, D	ury ay Year)	28b. Time o Injury	V	Vork?	28d. Describe	how injury	occurred	
VISION Attending r death.	he fu	catle	2 ☐ Accident investigation					☐ Yes 2 ☐ No	001 11	O+	Alumba a a a Cua	al Route Number,
	in by the	Certification;	3 ☐ Suicide 6 ☐ Could not to determined	286. Place of I	njury - At ho etc. <i>(Specify</i>		reet, factory, offic	<b>&gt;</b> 8	City or To		Number of hure	i node vanber,
Dital curs at urs at all aral	illedi	Ce	On Carting & Cartifying B	hysician: To the bes	t of my know	wlodgo dos	b occurred at the	time date and nia	ce, and due to the	causa(s) a	nd manner as s	stated
To tha Hospital o within 24 hours af To tha Funaral D	stely f	edical	29a. Certifier (Check only one)  Certifying P  Certifying P  Check only one)	miner: On the basis and manner:	of examinat	tion and/or in	ivestigation, in m	y opinion, death oc	curred at the time,	date and p	lace, and due t	o the cause(s)
To tha within 2 To tha	omple	Med	29b. Signature and title of certifier				29c. Lice	ense number		29d. Date	signed (Month,	Day, Year)
F- 3 F-	0		) Company	1			H5	8419		MAY	7,2005	c.
\			30. Name and address of person who	completed cause of	death (Item	1 23а) (Туре	Print)				,	
			RODNEY DONHAM D!	0, 1881 -	THUGOR	MPH R	bao Kis	ING SUN, i	MD 2191			
	Sta		31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ture	11	,				
Re	egistr	ar	MAY - 4 2005	please	No.	rg-				<u></u>		

			1 = For Stete Registrar	State of Marylan	-		of Health ar of Death	nd Mental H	/giene	10000
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last,     A. Facility Name (If not institution, give	LLIS KILL	NON	SR 4b. City, To	wn, or Location of	2. Date of D  Month  APPLL  Death		5 1400 M
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1		Hrs. 8. Date of B	WICON   irth   ay, Year)   / 1927	irthplace (State or Foreign Country)
	h the Maryland or 28a-f show	Director	10a. State 10b. County  MD VICOM  10e. Street and Number		y, Town or Lo		ode		10g. Citizen of What (	10d. Inside City Limits 1 ☐ Yes 2 💆 No Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene, If marked other than "natural; or itams 23a or 28a-f show tother traumatic event, the Modical Examiner must be notified at	Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:	'	Was Deceder f Yes, specify	,	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - An Black, Wt Specify:	nerican tndian, lite, etc.
Maryland 21215-0036	filed within 72 hour Hygiene. other than "natural ant, the Madical Er	Completed by	15. Decedent's Edu (Specify only highest grade	cation	(Give	OO NOT use	done during most o		16b. Kind of Busines	
laryland	2 should be file and Mental Hy Is markad oth aumatic evant	To Be (	17. Father's Name (First, Middle, Last) ROBERT KILL 19a. Informant's Name/Relationship (Ty	pe, Print)			18. Mother's	Name (First, Middle SIE LEE	BFNNE Ber, City or Town, State	Ü
a)	Pages 1 and 3 ment of Health ant: If Item 27 ury or other tr		20a. Method of Disposition  1 Serial 2 Cremation 3 GR 4 Donetion 5 Other (Specify)		Place of Disponementery, crem	natory or othe	CK RD of r place) ETERV S	Date /1/05	20c. Location - City of	1856 or Town, State
Balt	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensus  23a. Part 1. Enfel the disease, or complishock, or heart failure. List only or	cations that caused the death	6 Y	TESS	FUEIN	ERAL HO	ME POB	Approximate Interval Between
	Physician /Medical Examiner		tmmediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	uence of):	Nye	all	lmy (	d	Onset and Death 4 MO
3760,	te be executed ysician and te burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a) consequence to (or as a consequence to (or a) consequence to (or a) consequence to (or a						
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cords, P.	law requires that the de as been signed by the a 2 should be detached f	þ	Part II. Other significant conditions con	tributing to death but not resi	ulting in the un	nderlying caus	e given in Part I.	_ 10		robably 4 Unknown
Ï	The ate h page	Be Completed	25. Was case referred to medical examiner?				_	24a. Wa: auto peri 1 Yes Death (Check only	2 No 1 Ye	
o	ling Ph h. After th funeral	Certification: To	27. Manner of Death  Natural  Accident  Suicide  6 Could not be	ospital: 1  tnpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other: 4 Nursi Injury at Work? 1 Yes 2 No	28d. Describe	idence 6 □Other (Sp how injury occurred	
N N	spital ours cours harail	edical Certifi	4 Homicide determined  29a. Certifier (Check only) 2 Medical Examir	28e. Place of Injury - At he building, etc. (Specify lician: To the best of my knower: On the basis of examinal	wledge, death	occurred at t	he time, date and r	City or To	(Street and Number or F wn, State)	hates a
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner stated.						
g	Sta		31. Date filed (Month, Day, Year)	RASSO 145 32. Registrar's Signa	ture	Print) (APPR	ou St	- SALI	29d. Date signed (Mor 4/29/( Skynny	mo
	Registr	ar	MAY 0 5 20	105 Elatines	At for	OCHEL!				

Δ	mend #18	<u>Per FH PGC 5-4-05</u>		/ Department of F Certificate of	fealth and Mental Hy <i>Death</i>	giene 2005 15829
	Physician /Medical	Decedent's Name (First, Middle, La		chelski	2. Dete of Domestin Month May 2,	Day Year
st.	Examiner	A = 100 A1	· ·		4b. City, Town, or Location of Deal Crofton	
	Funeral Director	010-22-2807	7. Age (In yrs. last	st birthday) If Under 1 Year Months Days	Hours Min. 8. Date of Bi (Month, D.) June 2	9. Birthplece (State or Foreign Country) Pennsylvania
	Maryland f show	Usuel Residence of Decedent  10a. State  10b. County  Md.  Anne Ar		Town or Location Crofton		10d. Inside City Limits 1 ⊒ves 2 □ No
	offer death with the Ma or flems 23a or 28a-fa riner must be moffled Funeral Directol	10e. Street end Number 1903 Seven Oaks		10f. Zip Code	21114	10g. Citizen of Whet Country?
020	Je je	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Dates: WWII	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☒ No	ispanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.)  Specify:	
Maryland 21215-0020	ied within 72 hosygiene.  Ner than "naturally, the Wedical E.	15. Decedent's Ec (Specify only highest gre Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	16e. Decedent's Usuel Occup (Give kind of work done of life. DO NOT use retired Correctional	during most of working ()	16b. Kind of Business/Industry U.S. Govt.
yland	should be filed and Mental Hygic marked other umatic event, uratic event	17. Father's Neme (First, Middle, Last)	Andrew Kruchels	ki	18. Mother's Name (First, Middle  Josephine Me	, Maiden Surneme) nkarinko Unk.
e, Mar	1 end 2 sho Health and em 27 is m other traum	19a. Informant's Name/Relationship (1) Sophia M. Kruche 20a. Method of Disposition	lski - Wife		ks Terrace, Crof	er, City or Town, State, Zip Code)  ton, Maryland 21114
Baltimore,	Pege nent c ant: If any or	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify 21. Signature of Funeral SetVice Licen	Removal from State Mary	etery, crematory or other place land Veterans 22. Name and Address	Cemetery	Crownsville, Maryland
Ba	parmit. Departrimports imports any inji	23a. Part1. Enter the disease, or comp	Beall	6512 N.W.	Beall Fur Crain Hwy, Bowi	neral Home e, Maryland 20715
7	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	e. METAST		R UNILNOWN	Interval Between Onset and Death
, 0,	licate be executed physicien end s the burial-transit edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Due to (or e:	s a consequence of):		
Box 68760,	ificate p phys as the	resulting in death) Last	Due to (or es	s a consequence of):		
P.O.	d by the detached		entributing to death but not resulting	ng in the underlying cause give		tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
of Vital Records,	aw 2 s 2					en autopsy med?  24b. Were autopsy findings available prior to completion of cause of deeth?
/ital R	ician: The I certificate he rector, paga	25. Was case referred to medical examiner?			1 ☐ 1	- 1
on of \	사 등 는 는	1 Yes 2 No  27. Manner of Deeth 1 Naturel 5 Pending	1	/Outpatient 3 DOA Other b. Time of Injury M 28c. Injury Work	4 Nursing Home 5 ☐ Resid	dence 6 □Other (Specify) now injury occurred
á	tal or Attanding P rs aftar death. al Director: After t ad in by the funers Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At home building, etc. (Specify)			Street and Number or Rural Route Number, vn, State)
	To the Hospital within 24 hours of the Funeral I completely filled	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowled iner: On the basis of examinetion end menner stated.	dge, deeth occurred et the tim and/or investigation, in my op	e, date end place, end due to the inion, death occurred et the time,	ceuse(s) and manner es stated. date end place, and due to the cause(s)
	To the within 2 To the comple	29b. Signature and title of certifier	Vallace No	29c. License		29d. Date signed (Month, Day, Yeer) MAY 3, 2005
2	(10) WG	30. Neme end eddress of person who co	ACCACE, his	Pe) (Type, Print) POOS KIU	BRIDE RD BA	MAY 3, 2005 LTIMINE Mg 21236
	State Registrar	31. Dete filed (Month, Day, Year)  MAY 0 4 2005	2. Registrar's Signeture	breele		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrer Amend Items 24a, 26 per Verb, 843, 05/18/05dbb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month CARROLL 1201 PM LINK 05 08 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bathmore
If Under 1 Year | If Under 24 Hrs.
Days | Hours | Min. University Num Maryland Medical Center Birthplace (State or Foreign Country)

WV **Funeral 10** M 2 □ F Yrs. Director 60 233-68-1584 Usual Residence of Decedent Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other then "naturel", or Items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Completed by Funeral Director Washington MD Hagerstown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9709 Garis Shop Rd. 21740 USA death permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Importent: if filem 27 is marked other thermal any injury or other treummit 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🙀 Married 1 Yes XXNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist 12 Trucks 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray Link Ethel Dove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Lorraine Link (wife) 9709 Garis Shop Rd. Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Rio Cemetery Rio, WV 22. Name and Address of Facility McKee Funeral Home Inc. 21. Signature of Funeral Service Lice P.O. Box 270 Augusta, WV 26704 23a. Part1. Exter the disease, or complications that (caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Eschemic Immediate Cause (Final Physician Cordianyo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque ce of) resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ unsufficiency, vantucular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Be Completed VAD site infection 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 1 Yes 2X No Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending s after decral Director: Alte 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide P within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) AU4176435515240 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12

DHMH 17 Rev 1/2001

State Registrar South

31. Date filed (Month, Day, Year)

MAY 1 8 2005

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Sheet

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician Month 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Hospice at the Wicomico bastal ake If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 1**X**M 2□ F Months Yrs. 216-20-4370 Director 77 PÁ May 25, 1927 Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at Director 1 Yes 2 □ No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? I Harrison Ave. 21811 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1X Yes 2 No WW II 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: White Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Newspaper Publisher Newspaper othar unould be filt.

Tis mark. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Stuart Lohmeyer Angela Mullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health if itam 27 Patricia Lohmeyer I Harrison Ave., Berlin, Md. 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ŏ 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State ö permit. Page Department o Important: if Cape Henlopen Crem. 5-5-05 4 □ Donation 5 □ Other (Specify) Frankford, DE 21. Signature of Tuple at Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause in each line. 23a. Part1. Enter the disease. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentiary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed Due to (or as a consequence of): burial-1 Box 68760, physician ician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 5 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) **∠**No dire 2 1 🗌 Yes 1 Impatient s after dec. 2 ER/Outpatient 3 DOA 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONSTAL HOSPILE 10+1

DHMH 17 Rev 1/2001

State Registrar

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Physic	ian	1. Decedent's Name (A		<del>-</del>						2. Dete of I Month	Deeth Day	Year	3. Time of Death
/Med		Lawrenc			horn	1				May 1	2005		2:20PM
Exami	ner	4e Fecility Neme (If no						4	-	or Location of De		y of Deeth	
		St. Mary ' 5. Social Security Num			//	b - 4 ( * 4b	If Linds	er 1 Year	Leonar		St. M		
Funeral		578-16-748		M 2□F 7. A§		last birthdey) Yrs.	Months			Vin. (Month, I			lace (State or Foreig try)
Director		Usuel Residence of De	,		84			<u> </u>		07/31,	1920	Wash	D.C
filed within 72 hours efter death with the Maryland Hygiene. Wher than "natural", or frems 23a or 28a-f show ent, the Madical Examiner must be notified at		10a. State 10	0b. County		10c. City	, Town or Loc	cation					1	0d. Inside City Limits
Man Filed	to	MD Ca	alvert		Lust	bу							1 ☐ Yes 2 ☐ No
128 H	<u>Je</u>	10e. Street end Numbe	er		l		10f. Zi	p Code			10g. Citizen of	What Cour	ntry?
23a	a D	12955 Pari	ran Drive				206	510			USA		
s i end z should be nied winin /z hours effer death with the Marylar if Health and Mentel Hygiene. If Health and Mentel Hygiene than *natural', or flems 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	11. Maritel Status	1	2. Wes Decedent	Ever in U,	S. 13. V	Vas Dece	dent of H	ispanic Origin	? (Specify Yes or fuerto Rican, etc.)	io- 14. Ra	ce - Americ	
or the	Ē	1 Never Married	2☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	No 1943	<b>5</b> –				uerto Hican, etc.)		ick, White,	
- 5	ð.	3X Widowed 4	Divorced	Year or Dates:	1945	5   '	☐Yes	XX	Specify:		Specii	<sup>b</sup> ∵Whit	e
age age	Completed by	15 (Specify	. Decedent's Educ onfy highest grade	ation completed)		16e. Deced	ent's Usu	al Occup	ation during most of	workina	16b. Kind of B	Business/Ind	dustry
. F .	nple	Elementery/Seconda		College (1-4or	5+)				during most of				
t, Ferth	Co	9				Superv	/ison				Constru		n
a oth	Be	17. Father's Neme (Fire								Name (First, Midd		тө)	
Men	2	Howard Wil							Heste:	r Mae Wil	liams		
th and Mentel Hygiene. 7 is marked other than " traumatic event, the Mas		19a. Informant's Name								r Rurel Route Num	-	, State, Zip	Code)
Health em 27 rther tr		Linda Muli		hter		L				Lusby, MI			
		20a. Method of Disposit		moval from State		lace of Dispos emetery, crem				Date	20c. Location	- City or To	wn, State
entment of I ortant: If ite injury or or		4 Donation 5		moval nom State	Ced	dar Hil	L1 C€	emete	ry	5/5/05	Suitlar	nd, M	D
Depertment of important: If any injury or once.		21. Signature of Funer	al Service License	ell_		22. 4	Name a	nd Addres Pen	s of Facility (	Cedar H ania Av	ill Fun e. Suit	eral land	Home,Ir ,MD20746
		23a. Partt. Enter the c	disease, or complications. List only on	ations thet caused	the death							1	Approximate
nysician		SINGER, OF FIGAR 12	illule. List only on	e cause on eech ii	10.							1	Interval Between Onset end Death
Medical		Immediate Cause (Findisease or condition	al	Chron	ic O	bstru	cti	ve P	11 1 m o n a	ary Dis	2856	1	years
xaminer		resulting in death)	а			es a consequ				, DID			<del>Jear B</del>
-	ne			Conge					ure				years
physician end s the burial-transit	Examiner	Sequentially list condit	ions. b.			as e consequ							<del>,</del>
g physician end as the burial-transit	Ä	Sequentially list condit if eny, leading to imme cause. Enter Underlyin Cause (Diseese or injuthat initiated events	ndiaté ng									i	
he bu	edical	that initiated events resulting in death) Last	ry c.		Due to (or	as e consequ	ience of):						
CD 60		rosuling in doziny Last										} 	
attending I for use	an		d.										
ed fo	Physician/M	Part II. Other significar	nt conditions cont	ributing to death b	ut not resu	tting in the un	derlying	cause give	en in Part I.	23b. Di	d tobacco use co	ntribute to	the cause of death
by the steched	Phy	0		ъ.						10	Yes 2□ No	3 Prot	ably 4 ⊡tUnknow
igned be dete	by		ry Arte	-	ase					_			
ste has been signed by the attending pege 2 should be deteched for use.	Completed	Diabete	es Mell:	itus						24a. Wa	s an autopsy formed?	24b. We	re autopsy findings
SO	pie	l <del></del>		<del></del>			-			-		cor of o	npletion of cause death?
ete has pege 2	E									1	Yes 2XNo	1 🗆	]Yes 2⊡XNo
certificate rector, pe	Be C	25. Was case referred	to medical						26. Place of	Death (Check only	one)		
iis cer I direc	<b>1</b> 0	examiner? 1 ☐ Yes 2 ☒ No	Ho	spital:	nt 2 🗆 E	ER/Outpatient	3 🗆 D	OA Othe	ar.	g Home 5□Re		ner (Specify	()
= @		27. Manner of Death		28e. Date of Inju (Month, De	ry	28b. Time of		28c. Injury Work	- 20		how injury occur		/
r deeth. ctor: After ti by the funera	atio	1 Natural 5 2 Accident	Pending investigation	(World), Dej	r (ear)	Injury	М		Yes 2□No				
or deeth. ector: After by the fune	110	3 ☐ Suicide 6	Could not be determined	28e. Plece of Inj	ury - At hor	me, farm, stre	et, factor	y, office			(Street and Numl	ber or Rura	l Route Number,
i Dir	Certification:	4 I Tomicide		building, etc	:. (Specily)	)				Ony of T	own, State)		
within 24 hours after deeth.  To the Funeral Director: A completely filled in by the fu	edlcai (	29a. Certifier 1 (Check only one)	Certifying Physi Medical Examin	clan: To the best on the class of and manner sta	examinati	vledge, death on end/or inve	occurred estigation	at the tim	e, date and pla pinion, death o	ace, and due to the ccurred at the time	e cause(s) and ma , date and place,	anner as st	eted. the cause(s)
o the	Me	29b. Signature and title	of certifier					c. License			29d. Date signe	d (Month, I	Day, Yeer)
× ⊢ 0		1 1				MAN		)560	96			4-05	
0/1	)	20 Name and a	M	anintad account of the	th /!! - :	1011)	) Lilian						
KII		30. Neme and eddress			,		·						
		Rajbind 31. Date filed (Month, D	ler Gill	, M. D. Registre	240	35 3 ]	Note	h-R	oad, F	<del>lollywoo</del>	d, MD	2063	6
Sta Registr			n 5 2005	Z. Hogistii	Loughat	-	3-						

DHMH 16 Rev 6/95

			State of Manuage / Di	epartment of Health and M	-	_	<b>.</b>
			, FOI	Spartificate of Death		leg. No.2. 0 0	5 16000
			Decedent's Name (First, Middle, Last)	1	2. Date of Dea	th	3. Time of Death
	Physici /Medic		Hazel M. LOCKWOC	$\mathcal{A}$	Month Mav	01 200	A.A
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of D	
			Berlin Nursing & Rehabilitation Center		0.5-1. (5:11	Worce	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 7. Age (In yrs. last birth 90	Months Days Hours Min.	8. Date of Birth (Month, Day Feb. 28		Birthplace <i>(State or Foreign</i> Country) [aryland
			Usual Residence of Decedent		160. 20	, 1010   1	
	arylan	_	10a. State 10b. County 10c. City, Town				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h the Marylar r 28a-f ahow r notified at	ecto	Maryland Worcester Berli  10e. Street and Number	n 10f. Zip Code		log. Citizen of What	
	~ 0 *	Funeral Director	11003 Grey's Corner Road, Lot 59	21811		USA	
	death w ms 23a	nera	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-		merican Indian,
9	after or Ite	교	Armed Forces?  1 Never Married 2 Married I Yes, Sive	1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Specify:	/hite, etc.
003	72 hours after "natural", or Ite	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:			В	lack
15-	- 100	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Busine	ess/industry
212	d within jiene.	шо	Elementary/Secondary (0-12)   College (1-4or 5+)	orer		Seasonal 1	industry
1 2	ould be filed with Mental Hygiene arked other thai atic avent, Inc.	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name		,	
yla	should be filed withir nd Mental Hygiene. s marked other than umatic avent, to M	2	Howard Jones		ha Forer		
Maryland 21215-0036	12 sho h and 7 is mu iraum			Mailing Address (Street and Number or Run		r, City or Town, Stat	e, Zip Code)
	is 1 and 2 should of Health and Men itam 27 is marke other traumatic	1	20a Method of Disposition 20b, Place of I			Maryland 20c. Location - City	21804 or Town, State
<b>6 6</b>	Pages nent of int: If it iry or o		LA Burial 2 Cremation 3 Hemoval from State	crematory or other place)  1 UMC Ceme. 05/05/	/2005	Berlin, Ma	aruland
Baltimore,	permit. Pages Department of I Important: If its any injury or o	1	21. Signatur) of Funeral Service Licensee	22. Name and Address of Facility 1 21		Road - S	Salisbury, MD
3 8	Per E B		Muy Walley	JOLLEY MEMORIAL	CHAPEL		21801
7			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Physician	N 1	Immediate Cause (Final disease or condition	d denestra			Onset and Death  GLAS
	/Medical Examiner		resulting in death)  Due to (or as a consequence of	):			/
		<u>ا</u> ها	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	):			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				1
ó	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of	):			
8760,	icate be physici s the bu	dicai	d				
x 68	ath certific attending p for use as	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of	dalinon
Вох	atten after of for u	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	3 Ectopic pregnancy 5 Other (specify)		Month	Day Year
P.O.	t the de by the	hysi	9 Unknown				
	es that igned t be det		Part II. Other significant conditions contributing to death but not resulting in				e to the cause of death?
ord	v require been si should b	ted	Chonic obstructive pulmon	ary disease	1 🗆 Y	es 2 No 3	Probably 4 Hinknown
ec	e law r has be je 2 sh	Completed by	- Menia		24a. Was a autops	sy prior	autopsy findings available to completion of cause of
ЯН	ician: The l certificate ha ector, page		- diabetes mellins		performula 1 Tes		res 2□ No
Vita	sician: certifica rector,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ NO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outc	26. Place of Deat			
of	Phys ar this aral di	H	27. Manner of Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at		ence 6 Other (5 ow injury occurred	Бресіту)
ion	ittending F death. ctor: After ; the funer	atio	1 ☐ Matural 5 ☐ Pending (Month, Day Year) In 2 ☐ Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	r Atte er de racto racto	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Location (Si City or Town		Rural Route Number,
	itet o irs aft rel Di	Cer					
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, (Check only one)  1 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, for investigation, in my opinion, death occur	and due to the c red at the time, d	ause(s) and manner late and place, and	r as stated. due to the cause(s)
	o the	Med	29b. Signature and title of certifier	29c. License number	DE) 2	29d. Date signed (M	onth, Day, Year)
	->-0	1	1 Clestre Duffin us	C1-00067	95	5-2-0	5
			30. Name and address of person who completed the of death (Item 23a) (T	ype, Print) 209 COASTAL H			15, 2410 0
			KRISTINE GRIFFIN, MD 1	109 CONSTAL HI	64WA,	y, tevu	19944
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 0 4 2005	Last.			
	11091311		The second secon	refree			

			1 - State RegistAVEND#10a,b,c,e,	State of Maryland	-				0	000	10001
	Physici		Decedent's Name (First, Middle, Last,		1,10,10,10,10,10,10	imoute or	Douin	2. Date of De Month	ath Day	Year 2006	3. Time of Death
}	/Medio Examin		4a. Facility Name (If not institution, give Shady Grove Adver	street and number)			or Location of Deat		<del></del>	ounty of Death	1
	Funeral Director		5. Social Security Number 6. Se 577-20-7021		ast birthday) Yrs.	Rockv If Under 1 Year Months Days			th v. Year)	Cou	ry place (State or Foreign intry) hington, DC
	e Maryland ta-f show	ctor	Usual Residence of Decedent  10a. State MD 10b. County Mor	ntgomery 100. City	, Town or Lo OCkVil lexand	lle			-		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with th	al Director	10e. Street and Number 9701 Veirs Dri 740 Wost Clebe	ive <del>Road</del> ~		10f Zip Code 20850 - 22305	4		10g. Citize	n of What Cou	intry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 ie marked other than "neturel", or items 23e or 28e-f show or other treumatic event, the Medical Event war must be inclined at	by Funeral	11. Marital Status  1XXVever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Ameri Black, White, pecify: Whit	ican Indian, , etc.
21215-0036	l within 72 ho iene. r than "netur r'e Medicu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed)  College (1-4or 5+)	(Give life. i	dent's Usual Occup kind of work done DO NOT use retire Writer	during most of wo	orking		of Business/Ir	ndustry
Maryland 2	2 should be filed withir and Mental Hygiene. ie marked other than eumatic event, Tie M	To Be C	17. Father's Name (First, Middle, Last) Ralph Molster				Lydia	me (First, Middle,	Maiden Su	umame)	
	and 2 sh ealth and n 27 ie m		19a. Informant's Name/Relationship (7)  Kyle M. Holt/ Co	usin	740 1	West Gle	and Number or R	ural Route Numbe			
Baltimore,	Ly it e a		20a. Method of Disposition 1 □ Burial 2 【X*Cremation 3 □ F  `4 □ Donation 5 □ Other (Specify)	temoval from State Met	ace of Dispo emetery, crer ropolit	isition (Name of matory or other pla an Cremato:	ce) May	7 5, 005	20c. Loca	andria.	own, State  Virginia
Bal	permit. Departri Imports any inji	1 2	21. Signature of Funeral Service Licens	Jaller	22 Fi	Name and Addre rancis J. 00 Univer	ess of Facility Colling Sity Blv	Funeral	L Home	e Inc Spring	, MD 20901
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
-111	- 1	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, United and Thin y that initiated events resulting in death) Last	Due to (or as a consequence.	ience of):						I masth
68760,	cate phys the	dical	resulting in oealth) Last	Due to (or as a consequid.	ence of):						
O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Sc. If yes, outcome of pregnar 1  Live birth 2  Fetal 4  Pregnant at time of de 9  Unknown	death 3	Ectopic pregnanc Other (specify)	у		230	d. Date of deliv Month	very Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co.	ntributing to death but not resu	Ilting in the u	nderlying cause gr	ven in Part I.				the cause of death?
al Records,		Completed						24a. Was autor perio 1 ☐ Yes	rmed?	24b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of
of Vital	S S D	To Be	1 162 22 140		ER/Outpatien		26. Place of De		dence 6		- fy)
Division o	tending leath. tor: After the fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1 1	ryat rk? Yes 2 □ No	28d. Describe			al Route Number,
Div	i Sir de		4 Homicide determined	building, etc. (Specify	)			City or Tox	vn, State)		
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my	ppinion, death occi	e, and due to the urred at the time,	date and pl	ace, and due t	o the cause(s)
	Z witing	-	29b. Signature and title of certifier  Christee	Goorte			5 / 5 4 9		April	30	2005
_	_		30. Name and address of person who concluded the conclusion of the	ePoutre, M.D.	9901	Medical	Center [	Orive, Ro	ockvil	lle, MD	20850
	Sta Registi		31. Date filed (Month, Day, Year) MAY 0 4 200	39 Registrar's Signat	dos	ele)					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of			eg. No.	
	Physici /Medic		1. Decedent's Name (First, Middle, Las Neil Byron McAr					2. Date of Deat Month May		3. Time of Death 3. Tim
	Examin		4a. Facility Name (If not institution, give Casey House	street and number)		4b. City, Town, o	or Location of Death	1	4c. County of I	
	Funeral Director		362-20-4/32	7. Ag	e (In yrs. last birthday 81 Yrs.	// If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 19,	Year) 9.	Birthplace (State or Foreign Country) Michigan
	aryland show	Ļ	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	88a-f	ecto	Maryland Montgome	ery	Bethesda					1 □Yes 2X No
	with the	Dir	10e. Street and Number 8609 Rayburn Road	l		10f. Zip Code 20817			0g. Citizen of Wha USA	it Country?
ယ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Items 23a or 28a-f show any injury or other treumetic event, the Medical Examinat must be notified at ODGe.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ZWes 2 ☐ I	Ever in U.S. 13	. Was Decedent of I If Yes, specify Cub		pecify Yes or No- pecify Yes or No- pecify Yes or No-	Black, \	American Indian, White, etc.
Ö 003	hours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 No			Specify:	
Baltimore, Maryland 21215-0036	within 72 I one. ihan "nat	mpiete	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	)+)	edent's Usual Occup e kind of work done DO NOT use retire r Relation			16b. Kind of Busin Construct	
0 0	filled v Hygie other t		17. Father's Name (First, Middle, Last)		Labor	Relation		ne (First, Middle, M		1011
/lan	Wental Wental rrked otic ev	To Be	Millard Asher McA	rthur			Lena Ma	rie Rust		
Man	12 sho		19a. Informant's Name/Relationship (7			ling Address (Street				te, Zip Code)
ē,	ss 1 and 2 and Health au item 27 le		Elizabeth H. McAr 20a. Method of Disposition	thur/wife	20b. Place of Disp	Rayburn I		Date	20817 20c. Location - Cit	y or Town, State
E	Pages nent of int: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State		ematory or other pla del Crema:	1 110	y 4,	Odenton.	Maryland
Balt	permit. Departn Imports eny inju		21. Signature of Funeral Pervices Licent	POO OHA	MO1251 1	22. Name and Addre Going Home Beverly L	ess of Facility e Cremati	on Servi	ce P.O.	Box 784 ille, MD 21029
Г			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused one cause on each li	the death. Do not er	nter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		e Parkinso a consequence of):	on's Disea	ase			
	Examiner		Sequentially list conditions,	b						
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
60,	tificate be executed ig physician and as the burial-transit		that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
68760,	fficate t g physi	edical		d						
.O. Box	The law requires that the death cert te has been signed by the attending tage 2 should be detached for use s	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		23d. Date of Month	f delivery Day Year
Φ.	s that the ned by detact	by Phy	Part II. Other significant conditions co	ontributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did tot	pacco use contribu	te to the cause of death?
rds	w requires been sign should be	ted b	Advanced Dementia	a, Congest	ive Heart	Failure		1 □ Y€	es 2.∏No 3[	Probably 4 Unknown
I Records,	(2)	Completed						24a. Was an autops perform	y prior ned? deat	e autopsy findings available r to completion of cause of th? Yes 2 \( \) No
Vital	Physiclan: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		O#		th (Check only on		
o	dir.	n: To	1 ☐ Yes ZXXNo  27. Manner of Death	28a. Date of Inju		of 28c. Inju			once 6 XOther (	Specify) Hospice
ion	anding lath. or: Afte	atlor	1 ◯XVatural 5 ☐ Pending investigation		y Year) Injury		rk? ]Yes 2□No		, ,	
Division	tel or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of Inj	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (St. City or Town	reet and Number on, State)	or Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	dical	29a. Certifier (Check only one)	ysicien: To the best liner: On the basis o and manner st	of my knowledge, dea f examination and/or i ated.	ath occurred at the ti investigation, in my (	me, date and place opinion, death occu	, and due to the carred at the time, da	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
<b>\</b>	To t To tl	Me	29b. Signature and title of codifier			29c. Licens	se number	25	9d. Date signed (A	foлth.,Day, Year)
•			30. Name and address of person who d	completed cause of a	leath (Item 23a) (Free	Print	4127	3	5/0	3/05
			Charles Harrison	M.D. 6001	Muncaste		ad Rockvi	.11e, MD	20855	
	Sta		31. Date filed (Month, Day, Year)  MAY 0 5	A STATE OF THE PARTY OF THE PAR	ar's Signature	- 1 mm				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#25,77,28a-f, perme (846,8/11/1) IT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year frea MOLOCK 0150 M ernon 04 2005 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) Dorchester orchester Genera Year If Under 24 Hgs. Days Hours Min. Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 12 M 2□F 20-26-8993 Months Days Year) JUN. Director Yrs. Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 Dres 2 □ No Director ambrida 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21613 SA reenwood Ü Hvenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 12/Yes 2 12/1 No 11/Yes, Give / 9.5.2 Year or Dates: 1.9.5.3 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 2 12 No 1 🗆 Yes Specify: Black þ 3 Widowed 4 Divorced 1952 "natural" Completed 27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seafood Industry Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Molock Dernard 2 ce ravers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. C item 27 i other tra Blackwater MOLOCK Yudel reek ND. 21622 hunch ( 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of the Important: If ite eny injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery Church Creek, <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) inas Rd. 5 7/05 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the chath. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD. 2/6/3 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metas **Physician** Ta. CERTIFICATION APPROVED BY MEDICAL EXAMINER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last sician are burial-t Due to (or as a consequence of): Box 68760, Physician/Medical nding physics IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DM known been si 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ N 24a. Was an autopsy performed? Yes 2 2 20 certificate has irector, page 2 ubdula hematoma 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 100 1 X Yes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Driver in 28b. Time of Injury 28c. Injury at Work? After 5 Pending investigation Vatural. 3:30 PM 1 Yes 2 □No nerel Director: P 2 Accident 3 Suicide 5**/22/2000** truck/auto impact 6 Could not be determined 281 Location (Street and Number or Rural Route Number, City or Town, State) Rt. 335 nr. HipRoof Rd., Church Creek, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after To the Funerel Dire Roadway Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) a address of perso 30. Name and who completed cause of death (Item 23a) (Type, Print) NARR 0.0. 31. Date filed (Month, Day, Year) State 32 egistrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month nbert 0600 AM DIT 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 45 Delaware Ave., Apt. Hurlock Dorchester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 MM 2□ F 81 Director 293-90-0512 Yrs. May 11. 1923 | Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits freumetic event, the Medical Examiner must be notified at 1 es 2 No Director Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 45 Delaware Ave., Items 23a Apt. 22 21643 USA death Funeral 12. Was Decedent Ever in U.S. Armed Porces?

1 Dres 2 □ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō Completed by Specify: 3 A Widowed 4 □ Divorced WW II "neturel", White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Waterman 5 Shellfish 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Robert Miller Flora Lane ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: if item 27 is any injury or other tre once. Diane Willey/Daughter 5218 Sunflower Lane, Linkwood, MD 21835 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 5/3/2005 DorchesterMemPark 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, Maryland 22. Name and Address of Facility
Curran-Bromwell Funeral Home, P.A.
308 High St., Cambridge, MD 21613 21. Signature of Paneral Service Licensee notications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a Part Enter the disease, or companies. List only Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** ronout Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed orias a consequence of physician a Box 68760. Physician/Medical pendent CXIC IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month 4☐Pregnant at time of death Day Year 5 Other (specify) P.O. detached signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown page 2 should Be Completed 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Tyes 2XN0 Division of Vital 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: Certification: To 1 Tes 2 **2**00 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Sesidence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury Natural 2 Accident 5 Pending after death. М 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a
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completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier To the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D42005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 830 Chesapeake Drive, Cambridge, MD Michael Lees, M.D. 31. Date filed (Month, Playar) 3 200532. Reg State Registrar

		1	For State Registrar	State of	Maryland / De	partment ertificate		<u> </u>	Reg. No	2000	161	338
	Physicia /Medic	n al	Decedent's Name (First, Middle Raymond Francis     As. Facility Name (If not institution)	Motter	nber)	4b. City. To	wn, or Location	Monti May	1	y Year 2005 County of Dea	3. Time o	f Death P
	Examin Funeral	31	Union Hospital  5. Social Security Number	of Cecil	County 7. Age (In yrs. last birtha	Elkto	on	24 Hrs. 8. Date Min. (Mont	of Birth	9. Bir	thplace (State ountry)	or Foreign
	Director Modal		187 24 3612 Usual Residence of Decedent 10a. State 10b. County		78 Yrs			Jan.	21,192	27 Pen	10d. Inside C	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show yillight of the profiled and the profiled and the page.	Funeral Director	Maryland Cecil 10e. Street and Number 315 Colonial Di		Charlest	10f. Zip C	4		Unite	izen of What C	ountry?	2 _ NO
215-0036	hours after de urai', or items il Examiner m	þ	11. Marital Status  1 □ Never Married 2 ★ Mar  3 □ Widowed 4 □ Divorced	Armed Fo 1 X Yes If Yes, Giv Year or Da	rces? 2□No 1946— eates: 1947	If Yes, specify 1 ☐ Yes 2 2	Cuban, Mexica No Specify.	rigin? (Specify Yes n, Puerto Rican, et :	c.)	14. Race - Am Black, Whi Specify: W ind of Business	nite	
121215-	led within 72 l lygiene. har than "nat nt, the Wedie	Completed		t's Education st grade completed)  College (1	-4or 5+)	acedent's Usual ( live kind of work e. DO NOT use hinist	done during mos retired)	st of working er's Name (First, M	Auto	omotive		cturin
Maryland	2 should be fi and Mental F is marked ot aumatic ever	To Be	Joseph Motter  19a. Informant's Name/Relations		19b. M	ailing Address (S	Gert	rude Par	tsch		Zip Code)	
Baltimore, N	Pages 1 and lent of Health nt: if item 27 iry or othar tr		Susan Motter/W:  20a. Method of Disposition  20x Burial 2 Cremation  4 Donation 5 Other (S	3 □Removal from	State 20b. Place of D cemetery,	Colonia isposition (Name crematory or other ew Cemet	of er place)	May 7, 2005	Johr	ryland ocation - City or nstown, nsylvan	Town, State	
<b>Balti</b>	permit. Departm Importa any inju		21. Sign Jure 1 Funeral Service	al		22. Name and 127 Sout	Address of Facil h Main	Street, No	Funera orth Ea	11 Home	yland 2	te
	Physician /Medical .xaminer		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	ach line.  OS-GSSS  or as a consequence of)						Interval Be Onset and 3 de	Death ∑∫
8760,	ie be executed ysician and e burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consequence of)	ute V	T				3 We	ers
.O. Box 68	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	come of pregnancy irth 2 Fetal death ant at time of death own	3 ☐Ectopic preg 5 ☐ Other (spec			_	23d. Date of de Month		Year
<u>α</u>	v requires that the been signed by th should be detache	ted by Pr	Part II. Other significant condition Heuroschagic	Stroke o	Pright 6.	ne underlying cau	, «	l. 23e.		use contribute t		death? Unknown
tal Rec	The law ate has b page 2 si	e Completed by	Tenal In 25. Was case referred to medica	Officiery	Colifis		26. Plac	24a.		prior to death?	utopsy findings completion of d	available cause of
Division of Vital Records,	ding Phys I. After this funeral di	Certification: To B	3 Suicide 6 ☐ Could	28a. Date (Mon not be	of Injury - At home, farm	ne of 280	work?  1 Yes 2	]No	cribe how inju			nber.
Div	To the Hospital or Attand within 24 hours after death To tha Funaral Diractor: completely filled in by the	ledical Certif		ng Physician: To the	ng, etc. (Specify)  best of my knowledge, of asis of examination and/o	death occurred at	the time, date a	City and due t	or Town, State	a)  ) and manner a	s stated.	
_	To the H within 24 To the F complete	Medi	one)  29b. Signature and title of certific	and man	ner stated.		License number			te signed (Mon		
	10+14		30. Name and address of person	o MD	Union He	rpe, Print)		ousr E			2192	- [
	Sta Regist		31. Date filed (Month, Day, Year  MAY - 4 2005	Beau.	legistrar's Signature							

		1 - For State O: Registrar  1. Decedent's Name (First, Middle, Last)	f Maryland / Dep	artment of Health and rtificate of Death	-	ne 200	5 1683
Physici /Medic Examin	cal	Helen Mallard  4a. Facility Name (If not institution, give street and num		4b. City, Town, or Location of Dea	April 23	Day Year 2005 4c. County of Deat	3. Time of Death 7:08A
Funeral Director		Prince George Community  5. Social Security Number  238-72-6508  Usual Residence of Decedent	Hospital 7. Age (In yrs. last birthday, 61 Yrs.	Cheverly  If Under 1 Year If Under 24 Hr  Months Days Hours Mir	S. 8. Date of Birth (Month, Day, Yea	Prince Ge 9. Bin 1943 Nor	eorge  hplace (State or Foreign buntry)  th Carolina
r 28a-f show	rector	10a. State 10b. County Maryland Prince George 10e. Street and Number	10c. City, Town or L Capitol Ho		10g. (	Citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
filed within 72 hours after death with the Maryland Hygiene. Athar than "natural", or Itams 23a or 28a-1 show ant, I've Modical Exeminat must be notified a	by Funeral Director	5225 Marlboro Pike, Apt.  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Apriored  1 Yes If Yes, Giver Year or Description.	dent Ever in U.S. ces? 2 ⊠ No	20743  Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue  1□ Yes 2⊠ No Specify:	Unit	14. Race - Ame Black, Whit	es etc.
be filed within 72 ho ntal Hygiene. sd othar than "natur evant, I're Modical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1	-4or 5+) (Give life.	odent's Usual Occupation be kind of work done during most of with DO NOT use relired)  memaker	orking 16b.	Kind of Business	
9 4 5 5	To Be (	17. Father's Name (First, Middle, Last)  Unknown  19a. Informant's Name/Relationship (Type, Print)		Mary A	nme (First, Middle, Maide nn Forte		
1 and 2 Health a sm 27 is		Blanche Lewis/Cousin 20a. Method of Disposition	8837	ng Address (Street and Number or F Ritchboro Rd., I position (Name of matory or other place)	orestville,		47
permit. Pages 1 and Department of Heal Important: If item any Injury or other ODCS.		1	Harmony 1	Memorial ParkApri	1 30,2005 L Cope Funeral 538 Marlbor Corestville,		MD.
Pnysician /Medical Examiner	ner	Sequentially list conditions, if any, leading to immediate  Due to (conditions).  Due to (conditions).	used the death. Do not entach line.  Sive Hemoptysor as a consequence of):  monary As, er; or as a consequence of):	ter the mode of dying, such as cardiasis	or respiratory arrest,	, FID. 20	Approximate Interval Between Onset and Death 2 hours
certificate be executed thing physician and tse as the burial-transit	Ical Examiner	resulting in death) Last C. Due to (c	rocystic Pulmoras a consequence of): monary Sarco	monary Disease idosis			1997
death certific e attending p id for use as	hysician/Med	in the past 12 months?	ant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deli	very Day Year
w requires that the been signed by th should be detache	by P	Part II. Other significant conditions contributing to de	ath but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco		the cause of death?
The law ate has b page 2 st	e Completed	25. Was case referred to medical			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
Phys this al dii	ertification: To Be	examiner?  1 Yes 2 XNo  Hospital: 1 Ir Ir  27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation  1 X Accident	patient ZEP/Outpatier f Injury c, Oay Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing	ath (Check only one)  Home 5 Thesidence 28d. Describe how inj		nfy)
To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the funer	O	29a. Certifier 1X Certifying Physician: To the	of Injury · At home, farm, str g, etc. (Specify) best of my knowledge, death	h occurred at the time, date and place	28f. Location (Street a City or Town, Sta	te)	etated
To the Ho within 24 t To the Fu completely	Medical	(Check only one)  2 Medical Examiner: On the ba and mann  29b. Signature and title of certifier	sis of examination and/or in	vestigation, in my opinion, death occ	urred at the time, date at	nd place, and due ate signed (Month	to the cause(s)
(e)		30. Name and address of person who completed cause Louis Steinberg, M.D. 6		,	•	- 26 -	2005
Sta Registra	_	31. Date filed (Month, Day, Year)  MAY 8 4 2005	gistrar's Signature	W			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 2005 **Physician** 10:04P M Stephanie Middaugh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Cheverly Prince George's Hospital 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 14,1925 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 💢 F Germany 273-36-3167 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location Itam 27 is marked other than "natural", or Itema 23s or 28s-1 show other traumatic event, the Medical Exercit at must be notified at 1 XYes 2 No Director Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20715 12319 Kemmerton Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Marned Specify: White 1 ☐ Yes 2 No Specity: Baltimore, Maryland 21215-0036 Š 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) 2 School Principal Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hedwig Schmiga Florian Kroll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mit. Pages 1 and 2 st partment of Health are portant: If Itam 27 is r Ratingen, Germany 40882 Hahnerhof #2 Christina Messer / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Denation 5 □ Other (Specify) permit. Page Department of Important: If any injury of once. 05/20/2005 Arlington VA Arlington Nat. Cem. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD. 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIAC ARRHYTHMIA Immediate Cause (Finat disease or condition resulting in dealh) FATAL Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Phyaician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No į 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown as been si Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmed? r this certificate har ral director, page 1 ☐ Yes 26. Place of Death Check on one 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ٩ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After 5 Pending investigation 1 X Natural To the mospherical within 24 hours after death.

To the Funaral Director: After the funaral in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DD061896 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) CHEVERLY UD 20185 DMITH 3001 ED WARD KEED . Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland partment of Health and Mental Hygier Sertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Maefield W. Mills 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cedar Crest Nursing Home Hyattsville Prince Georges 8. Date of Birth (Month, Day, Year)
Time 23, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2√□ F 94 579-26-4265 Yrs. Director 1910 Usual Residence of Decedent 10a. State 10c. City, Town or Location r then "neturel", or items 23s or 28e-f show the Medical Examinar must be notified at 10d. Inside City Limits MD Prince Georges Director Glendale 1 TYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11802 Lillium Lane 20769 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 E No Specify: þ Specify: 3 分Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil ment of Health and Mental H tent: If item 27 is marked oth jury or other treumetic even George Wilson Lillie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian M.Dodson-Daughter 11802 Lillium Lane, Glendale MD. 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department o Importent: If any injury or once. 1★ Burial 2 Cremation 3 Removal from State Md.Nat'l Cem. ' 4 □ Donation 5 □ Other (Specify) 4-26-2005 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examine or Attending Physicien: The law requires that the death certificate be executed 0 Due to (or as a consequence of): Completed by Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4□Pregnant at time of death signed by the at I be detached fo 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 No 1 Tes 4

✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death the 3 ☐ Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 1 Queens home wend non 31. Date filed (Month, Day, Year) State APR 2 8 2005 Registrar

		State of Maryland / Department of Health and M  1 - State Registrar  Certificate of Death		giene	E 10010
		Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
Physici /Media		MARY ELLEN BURGESS NEAL	Month MAY		05 4:45 A <sup>M</sup>
Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Locetion of Death		4c. County of	
		CIVISTA MEDICAL CENTER LAPLATA  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birtl	h s	RLES  Birthplace (State or Foreign
Funeral Director		218-22-0987 1 M 2 F 96 Yrs. Months Days Hours Min.	OCTOBER 2	21, 1908 F	PENNSYLVANIA
pu 🖈 :-		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
f shov	ō	MARYLAND CHARLES BRYANS ROAD			1 Yes 2 No
r 28a-	rect	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Country?
ING 21215-0036  be filed within 72 hours after death with the Maryland hat Hygiene. Id Hygiene. Id other then "naturel", or Items 23a or 28a-f show event, the Medical Examinat must be redified at	Funeral Director	2832 MARSHALL HALL ROAD 20616		UNITED S	TATES
er dea	uner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe Armed Forces? 14. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc.
D36	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ □ No If Yes, Give 1 □ Yes 2 ሺ No Specify: 3 1 □ Yes 2 ሺ No Specify:		Specify:	BLACK
215-0036 Ithin 72 hours afi ien "naturel", or Medical Exami	ted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working) (Give kind of work done during most of working)	20	16b. Kind of Busi	
iffin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		- EDITO - ED	- O.V
N p b b		5+ SCHOOL TEACHER/ SUPERIN  17. Father's Name (First, Middle, Last)  18. Mother's Name			
ylanc outd be f Mental t arked of	To Be	100		IS BURGES	
Maryland d 2 should be file th and Mental Hy 27 Is marked oth treumatic event	F	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural			
		CLAYTON D. NEAL / SON 11860 OAK MANOR DRIVE,		•	
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Baltimore, permit. Pages 1 ar Department of Hea Importent: If item any injury or othe once.		*4 Donation 5 Other (Specify)  ARYLAND VETERANS CEM MAY 9  21. Signature of Funeral Semilar in the semilar in t	-	CHELTENH	AM, MARYLAND
Ba perm Depa Impo any i		21. Signature of Funeyal Serve Live Andreas of Facility  LYDIA C. THORNION JOHNSON MOO583  22. Name and Address of Facility  THORNION FUNERAL HOME, P  3439 LIVINGSTON ROAD, INI	'.A. Yan head	MARYI AND	20640
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician		Immediate Cause (Final disease or conditiona. Acute myocardial infarction			Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of):		-	
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uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			N.
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8760 rate be e	dicai	d			
Box 68 leath certifice attending pt	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		22 d Doto	of delivery
BO leath c	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of Month	
at the de by the d	hysi	9 Unknown			
<b>-</b> 2 2 8	by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ute to the cause of death?
ecords, law requires t as been signe	eted		1 U Y	es 2 No 3	☐ Probably 4♥☐Unknown
II Rec	Completed		24a. Was a autop	sy pric	re autopsy findings available or to completion of cause of ath?
		25. Was case referred to medical 26. Place of Death	1 ☐ Yes	2 No 1	Yes 2 No
Y VITAL ysicien: is certifica director, p	To Be	examiner?		ence 6 Other	(Specify)
o ਵ ਦੁਵ				ow injury occurred	
ISION Meath. death. ctor: Af	catic	2 Accident investigation M 1 Yes 2 No			
DIVISION  I or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (S City or Tow		or Rural Route Number,
To the Hospitel within 24 hours a To the Funerel I completely filled		29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	ind due to the d	ause(s) and mann	er as stated.
he Ho n 24 t he Fui pletely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time, o	date and place, and	d due to the cause(s)
DIVISIO To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier,  29c. License number		29d. Date signed (	
		Mr. Hank. DH-0058095	4	05/00/20	005
BRID		30. Name and address of person who a multipled cause of death (Item 23a) (Type, Print)  TONYA L. HARDE MD 11345 PEMBROOKE SQUARE WALI	OORF M	ARYLAND	20603
Sta	ate	31 Date filed (Month, Day, Year) 32. Projetrar's Signature			
Regist		MAY 0 5 2005 Seem & species			

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			Decedent's Name (First, Middle,	Last)		00,	imouto	0, 2		2	. Date of De	ath		3. Time of Death
	Physici /Medio		ANTHON	Y H. NGUY	EN					1	MAY 1,	20ª	05 Year	4:10 A M
7	Examin		4a. Facility Name (If not institution,				4b. City, To	wn, or	Location o	f Death		40	. County of Death	
	Formers		SHADY GROVE ADV  5. Social Security Number		AL ge (In yrs. last b	irthday)	ROCKV If Under 1		If Under 2	24 Hrs. 8	. Date of Bir		ONTGOMER 9. Birth	Y splace (State or Foreign
	Funeral Director		586-56-3281	1 M 2□ F	39	Yrs.	Months [	Days	Hours	Min.	(Month, Da	y, Year)	965 VIET	intry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	ocation							10d. Inside City Limits
	Maryl	tor	MARYLAND MONTGO	MERY	GAITHE	RSBU	JRG							1XYes 2□No
	or 28a	Director	10e. Street and Number				10f. Zip C	ode				10g. Ci	tizen of What Co	untry?
	s 23e		10705 DONOVAN CO			11	20879					U.S		
980	d 2 should be filed within 72 hours after death with the Maryland it and Mental Hyglene. It is marked other than "neturel", or Items 23e or 28e-f show treumatic event, the Modical Exciping constitution at	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces  1  Yes 2 4  If Yes, Give Year or Dates:	Ever in U.S. No		Was Deceder If Yes, specify 1 ☐ Yes 2	/ Cubar	spanic Orig n, Mexican Specify:	in? (Speci , Puerto Ri	fy Yes or No can, etc.)	)-	14. Race - Amer Black, White Specify: AS	
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	1 an Heal Bm 2		DUC VAN NGUYEN-F  20a. Method of Disposition	AIREK	20b. Place	of Dispo	sition (Name	of	1	Dat			ocation - City or 1	
E O	eg 5 <del>7.</del> 2		1 ☐ Burial 2 ☐ Cremation  1 ☐ Donation 5 ☐ Other (Sp		'		natory or other	•	. !	5-3-0	5	FAL	LS CHURC	CH, VA
Baltimore,	permit. Pag Department Importent: any injury once.		21. Signature of Formati Service	00500									RAL HOME	
	40244		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause	d the death. Do	_							IRGINIA	Approximate
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	/Medical Examiner		resulting in death)	Due to (or	a consequence	e of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							10 caqs
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8760,	cate b physic the b	dical		d.										
). Box 6	ie death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		of pregnancy 2 Fetal deal at time of death		⊒Ectopic preg ☐ Other (spec						23d. Date of deli Month	very Day Year
P.0	es that the digned by the be detached		9 ☐ Unknown  Part II. Dthar significant conditio	ns contributing to death I	out not resulting	in the u	nderlying cau	se give	n in Part I.		23e. Did t	obacco	use contribute to	the cause of death?
rds,	w requires been sign should be	ed by									1 🗆	Yes 2	<b>1</b> 3 □ Pro	obably 4 Unknown
Il Records,	The lay ate has page 2	Completed									24a. Was autop perfo 1 Yes		prior to death?	opsy findings available ompletion of cause of 2□ No
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of		n: To	27. Manner of Death	28a. Date of Inj (Month, Da	ury 28b	. Time o		. Injury Work			d. Describe		6 □Other (Specing occurred	ny)
sion	Attending r death. ector: After by the fune	atio	1 Katural 5 Pending 2 Accident investig	ation	ay reary	Injury	М		'es 2 □!	No				
Division	i Sir e	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ijury - At home, tc. (Specify)	farm, st	reet, factory,	office		28	f. Location ( City or To	Street al wn, State	nd Number or Ru e)	ral Route Number,
	To the Hospitei within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier 1 Cartifying (Check only one) 2 Madicat E	g Physician: To the best Examiner: On the basis and manner s	of examination a	ge, deat and/or in	h occurred at vestigation, in	the time	e, date and inion, deat	d place, an	d due to the at the time,	cause(s date an	and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier		_				number			29d. Da	ate signed (Month	
						1 (190			8/7			May		05
R	(3)		30. Name and address of person of HOSPITAL, 9901 M				DK	. SH	IAHYA MAR	R GAR YLAND	ACHOLO 2085	OU, 50	SHADY GR	LOVE AVENT.
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 4 2	005 Elder	trar's Signature	for	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month **Physician** Year AMES 46 /Medical 2005 DEL 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** University of MARY LAND MEDICAL SYSTEMS BALAMERE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 3 1943 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1(XM 2□ F 220-40-6986 Director Nov PG County, Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-1 shov Completed by Funeral Director Frederick 1 ☐ Yes 2 🕅 No Jeferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2209 Gapland Road 21755 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status traumatic evant, the Madical Exaction filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural 15. Decedent's Education (Specify only highest grade completed) . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is markad othar than Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming--Beff Cattle 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman W. Pyles Cora L. Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Pyles, Wife 19028 Sandy Hook Road, Knoxville, MD 21758 item 27 othar to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If any injury or \* 4 □ Donation /5 □ Other (Specify) Hagerstown Crematory 5/2/2005 Hagerstown, MD 21. Signaya ( u.e.) Service | cense-Barbara A. Willi 22. Name and Address of Facility Mami John T. Williams Funeral Home 100 petersville Road, Brunswick, MD Williams, Owner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory whilest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) APPROVED /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) the IF FEMALE esn If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy õ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death Check onl. one Hospital: Other: 2 1 ☑ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Certification; 28d. Describe how injury occurred Injury 1 Natural 5 Pending 2 □ No death. 2 Accident investigation 27 2009 14:55 after death Diractor: 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a, Certifier

Box 68760. P.0. Division of Vital Records. tha Hospital or Attending Physician: n 24 hours af 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause s) and manner as stated Medical Properting Physician: 10 the best of my knowledge, beath occurred at the lime, date and place, and due to the cause(s) and manner stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 Mame and address of completed cause of death (Item 23a) (Type, Print) Greare St outh BALTI MOM 31. Date filed (Month 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Security   Security Number	iene <sub>9g. No.</sub> 2005 - Look
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S. Social Security Number   S. Sex   24.8—4.2—938.7   1   M SQF   7. Age (in yes, lest circles)   University   1   University	4c. County of Death Prince Georges
Top   December   Dec	9. Birthplace (State or Foreign
To Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maxien Sumam)  19. Making Address (Street and Number or Rural Route Number, City or Town, 19. Informatis Name)  19. Informatis Name (First, Middle, Last)  19. Informatis Name (First, Middle, Maxien Sumam)  10. Informatis Name (First, Middle, Maxien Sumam)  10. Informatis Name (First, Middle, Maxien Sumam)  10. Informatis Name (First, Middle, Maxien Sumam)  10. Informatis Name (First, Middle, Maxien Sumam)  10. Informatis Name (First, Middle, Maxien Sumam)  10. Informatis Name (First, Middle, Maxien Sumam)  10. Informatis Name (First, Middle, Maxien Sumam)  10. Informatis Name (First, Middle, Maxien Sumam)  10. Informatis Name of Date Of Other Jobs of Date Of Other Jobs of Other Jobs of Other Jobs of Sacket Name of Date Office Name of Date Office Name of Date Office Name of Date Office Name of Date Office Name of Date Office Name of Date Office Name of Date Office Name of Date Office Name of Date Office Name of Date Office Name of Date Office Name of Date Office Name of Date Office Name of	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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23a. Part   Effect the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	16b. Kind of Business/Industry  Government
23a. Part   Effect the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	Aaiden Sumame)
23a. Part   Effect the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	
23a. Part   Effect the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	20c. Location - City or Town, State  andover, Md.
23a. Part I. Effect the diseases of complication of the course of the co	ville, Md. 20747
Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying by the underlying cause death of the policy o	Approximate Interval Between Ogset and Death
IFFEMALE:   23b. Was decedent pregnant in the past 12 mg/mths?   1   Yes   2   No   9   Unknown   1   Live birth   2   Fetal death   4   Pregnant at time of death   5   Other (specify)	
25. Was case referred to medical examiner?    Column   Co	23d. Date of delivery Month Day Year
25. Was case referred to medical examiner?    Column   Co	acco use contribute to the cause of death?
27. Manne of Death 1 Action of	prior to completion of cause of death?
3   Suicide 4   Homicide   Street and Number	nce 6 Other (Specify)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)	eet and Number or Rural Route Number, State)
I SED IN L	use(s) and manner as stated. te and place, and due to the cause(s)
29b. Signature and title of pertifier  29c. License number  29d. Date signed	d. Date signed (Month, Day, Year)
30. Name and iddres person who completed cause of death (Item 23a) (Type, Print)	True 76, 2003
30. Name and oddres person who completed cause of death (Item 23a) (Type, Print)  TAMES 4 SHERO N.S. 575 MAIN STREET SOITE 351  State Registrar  MAY 0 5 2005	LAUREL DO 707

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2005 7:00 P M Howe11 Peacock May Raymond /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**X** M 2□ F Days Director 216-60-0949 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Illimportant: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Ite Modest Examples to attend to a page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MDPrince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 Completed by Funeral 9626 51st Place USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (its only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Salesman Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edmund Clementh Peacock Zella Elizabeth Lohman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9626 51st Place, College Park, Maryland 20740 Joann Peacock, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □Donation 5 □ Other (Specify) Fort Lincoln Cemet. |05/07/2005 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infanction **Physician** 14 days /Medical Due to (or as a consequence of): Examiner Atheroselerons Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Hyperterising and Diabetes the attending physician and resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vanuelar 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannor of Death 1 Natural completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$100 Goodback Rd, Lunham, MD 20706 Sridhar Chatrathi, MD 302 31. Date filed (Month, Day, Year)
MAY 0 5 2005 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 81 2005 Peterson 6:55AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Prince Georges Washington Adventist HOspital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 8. Date of Birth (Month, Day, Ye Feb. 2, 1 Birthplace (State or Foreign Country) Days 1 ☐ M 2 🗗 F 93 579-48-5952 Yrs Director 1912 South Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location in then "natural", or items 23e or 28e-f show the Medical Examinan must be notified at 10d. Inside City Limits D.C. Washington Director 1⊠Yes 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 20011 321 Nicholson Street N.W. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 XNo Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) 6th. Domestic USA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental H John Goodman Charlotte Toliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Moses Manigan/Nephew 5303 South Dakota Ave. N.E. Wash. D.C. 20011 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H importent: If ite any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Lincoln Memorial Cem. 05-12-05 Suitland, MD. 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses - amai 4217 9th. St. N.W. Wash. D.C. 20011 23a. Phys. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequ Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown signed by t Part II. Dther cignificent conditions computating to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 3 Probably 4 Unknown 1 ☐ Yes 21 No Deen R4a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page perform rmed? 200 No this certificate 2 No 1 Yes 1 Yes director Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 2 1 ☐ Yes 2 XNo Other: 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours at To the Funerel D filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical npletely (Check o 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

31. Date filed (Month, Day, Year)

MAY 0 5 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

Nasreen Kango, M.D. 7610 Carroll Avenue, Takoma Park, MD.

20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death April 3() 2005 Sarah J. Pullev 11:10A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year) | May 10, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🛱 F South Carolina 228-30-0758 83 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Maryland | Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1310 Capitol View Terrace 20785 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: **Black** Specify 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Wright Salley Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda P. Smith - Daughter 1310 Capitol View Terrace Landover, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) em 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Center Rabun Baptist 5/7/2005 Gray Court, SC \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Sign, ture of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., DC OM Kluda 0 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Pneumonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Congestive heart failure Deconditioned resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2, No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 1 ☐ Yes 2 ☐ No 2. No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 M DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

**Examiner** aw requires that the death certificate be executed P.O. Box 68760, the attending physician Division of Vital Records. been this certificate After

use as the burial-transit signed by t Id be detach death. efter death

**Physician** 

/Medical

**Examiner** 

Director

Funeral

à

Completed

Be

Examiner

Physician/Medical

Be

Certification:

3 Suicide

29a. Certifier (Check only one)

4 Homicide

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itel any injury or other traumatic event, the Medical Examinat

**Physician** 

/Medical

Saltimore, Maryland 21215-0036

with the Maryland

death 1

Registrar

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 3a) Type, Print)

and manner stated

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D58965

May 1, 2005

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

11119 Rockville Pike, #100, Rockville, MD Saima Khawaja, M.D.

31. Date filed (Month, Day, Year)

MAY 0 4 2005

6 Could not be determined



			1 - For Stete Registrar	State of Maryla		artment of Health		/giene	2000	1681.0
	Physici /Medic		Decedent's Name (First, Middle, L     Philomena	Veronica	Poli	castro	2. Date of D Month May 3	eath Dav	Year	3. Time of Death 4:40 P M
	Examir		4a. Facility Name (If not institution, g 991 Almas Way 5. Social Security Number 6.	ive street and number)  Sex 7. Age (In yrs		4b. City, Town, or Location  Lothian  If Under 1 Year   If Under	of Death	4c. Ar	County of Death	de l
	Funeral Director		098-10-4092 Usual Residence of Decedent	1 M 2 M F 87	Yrs.	Months Days Hours	Min. (Month, D	ay, Year)	918 New	place (State or Foreign htry) York
	he Marylar 8a-f show cilled at	ector	MD Anne A	_	ity, Town or Lo .othian					0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with t	al Dir	10e. Street and Number 991 Almas Way			10f. Zip Code 20711		-	zen of What Cour JSA	ntry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show may injury or other traumatic event, it a Modical Exter it at must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  XXWidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic On If Yes, specify Cuban, Mexica	in, Puerto Rican, etc.)		14. Race - Americ Black, White, Specify: Whi	etc.
1215-0	within 72 ho	mpletec	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during mod DO NOT use retired)	st of working		nd of Business/Inc	ŕ
Maryland 21215-0036	should be filed ind Mental Hygis marked other umatic evant, II	To Be Co	17. Father's Name (First, Middle, Las Ahilio Pucci	st)	Jec	18. Moth	er's Name (First, Middle	e, Maiden :		nufactory
	is 1 and 2 sho of Health and I itam 27 is ma other traums		Dolores Kusman  20a. Method of Disposition	- Daughter	991	ng Address (Street and Numb Almas Way, Lo	er or Rural Route Numb	er, City or 2071:	1	
Baltimore,	nit. Pages artment of P ortant: If its injury or of		1 X Burial 2 Cremation 3 4 Donation 5 Other (Spec	Res	surrect	position (Name of matory or other place)			nton MD	
ä	permit. Departr Imports any inji		Mark H. Bec	Laure		Name and Address of Facil Huntt Funeral P.O. Box 156,	Waldorf, M	ID 20	0604	
	Prrysician /Medical Examiner		23a. Pari1. Enter the disease, or conshock, or heart failure. List only disease or condition resulting in death)	y one cause on each line.	RY.	er the mode of dying, such as				Approximate Interval Between Onset and Death
	cuted br ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a consec	quence of):					
8760,	cate be executed physician and the burial-transit	dlcal Ex	resulting in death) Last	Due to (or as a consec	quence of):					
P.O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of of 9 Unknown	al death 3[	Ectopic pregnancy Other (specify)		2:	3d. Date of delive Month	ry Day Year
ords, P	w requires that been signed b should be deta	ed by Pl	Pan II. Other significant conditions		sulting in the u	nderlying cause given in Part	1.0	tobacco us		e cause of death?
Division of Vital Records,		Completed					24a. Was auto perfo 1 □ Yes	psy ormed?	prior to con death?	osy findings available inpletion of cause of 2 No
Z.	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	Othor	of Death (Check only ursing Home 5 Res		FIGH	
sion of	문문문	Certification; T	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28d. Describe			9
<u>N</u>			4 Homicide determine	building, etc. (Speci	fy) 		City or To	wn, State)	Number or Rurai	
	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	edical	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Exe	hysicien: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the time, date ar vestigation, in my opinion, dea	nd place, and due to the ath occurred at the time,	date and	and manner as sta place, and due to	ated. the cause(s)
	To the within 2 To tha complet	M	29b. Signature and title of certifier	m.	٥	29c. License number	70		signed (Month, E	
T	ВЗ Sta	te	30. Name and address of person who Peter L. Wisnier 31. Date filed (Month, Day, Year)	wSki, M.D., 11(	) Hospi		, Prince Fr	ederi	ick, MD	20678-4041

88			1 - Stete Unpend Item	State of M 23a&27 per	laryland r <b>me</b> G	1/Depa	artment of H	lealth a	and Me	ental Hy	giene	2005	16850
	Physicia		Hegistrar     Decedent's Name (First, Middle, Last     Mari Jayne RODEF	t)			imouto or i	Journ		2. Date of De Month May 1	ath Day	005 Year	3. Time of Death 10:59 P M
	/Medic Examin	al	4a. Facility Name (If not institution, give	street and number	)		4b. City, Town, or		of Death	riay 1	4c.	County of Death	
			Washington County 5. Social Security Number 6. S		ge (In yrs. Ia	ast birthday)	Hagerstov	√N If Under	24 Hrs.	8. Date of Bir	th	shington	
	Funeral Director			□M 2 <b>K</b> F	3-(-)	Yrs.	Months Days	Hours	Min.	Month, Da Feb.5,	ıv. Year)		place (State or Foreign Intry) Land
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or La	ecation						10d. Inside City Limits
	Mary a-f sho	tor	Maryland Washing	ton		Hag	gerstown						1⊠Yes 2□No
	or 284	Director	10e. Street and Number		•		10f. Zip Code	017/0			_	izen of What Cou	intry?
	eath w	Funeral	231 Summit Avenue	12. Was Deceden	t Ever in U.S	S. 13. 1		21740		ify Yes or No	US -	SA 14. Race - Amer	ican Indian,
920	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 is marked other than "natural", or Itams 23a or 28a-f show traumatic evant. The Medical Examinar must be notified at	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ₹ If Yes, Give Year or Dates:	?  No	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:		lican, etc.)		Black, White Specify: wh:	
15-0	"natur	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during mos	st of working	g	16b. Ki	ind of Business/l	ndustry
212	e filed within al Hygiene. I other then "	ошо	Elementary/Secondary (0-12)	College (1-4or	5+)	none	DO 1401 236 1611160	,,			r	none	
Maryland 21215-0036	be filed tal Hygie d other evant.	Be C	17. Father's Name (First, Middle, Last)		· ·			18. Mothe		(First, Middle			
ryla	should be and Mental marked o	은	Steven Rodeffer,			19b. Mailir	ng Address (Street	and Numbe		sica Mu			in Code)
	Health and the tam 57 is mother traumother t		Jessica Murray -	**			Summit Av				-		
Baltimore,	ges 1 and of Healt if itam 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State			osition (Name of matory or other plac			ite		ocation - City or T	
Iţi m	it. Pag intment intent: njury		* 4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		Ceda		n Mem. Pa					erstown RAL HOM1	, Maryland
Ba	permit. Pages 1 s Department of He Important: If itam any injury or oth	1 1	Scott MI	Merries									land 21740
г	- 1		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that cause one cause on each	d the death. line.	. Do not ent	er the mode of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	4.			th Syndroi	ne					Onsot and Boain
ľ.	Examiner		Sarventially list conditions	Due to (or a	s a cons <del>o</del> qu	erice orj.							
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consequ	ianea cf):							
,092	sate be executed oblysician and the burial-transit	Ical Ex	resulting in death) Last	Due to (or a	s a consequ	ence of):							
.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)				:	23d. Date of deli Month	very Day Year
4	The law requires that the ste has been signed by th bage 2 should be detache	by Ph	Part II. Other significant conditions of	ontributing to death	but not resu	lting in the u	inderlying cause giv	en in Part I	I.	23e. Did t	obacco u	use contribute to	the cause of death?
Records,	w require been sig should b									10	Yes 2	□No 3□Pro	bably 4 Lunknown
3ec	has b	Completed				<u> </u>				24a. Was auto			opsy findings available ompletion of cause of
Vital	ician: The l certificate ha rector, page	a)	25. Was case referred to medical					26. Place	e of Death	1 X Yes (Check only o	2□ No one)	1 X Yes	2□ No
of V	Physician: this certificatal director, I	To B	examiner? 1% Yes 2 No	Hospital: 1 ☐ Inpat		ER/Outpatier						6 □Other (Spec	ify)
	Jing After fune	tlon;	27. Manner of Death  1 XNatural 5 Pending 2 Accident Investigatio	28a. Date of In (Month, D	ury ay Year)	28b. Time o Injury	Wor	yat k? Yes 2 □		8d. Describe	how injur	ry occurred	
Division	or Attanuiter deatl Diractor: in by the	Certification;	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of I	njury - At ho etc. (Specify	me, farm, str	reet, factory, office			8f. Location ( City or To			ral Route Number,
	To the Hospital or A within 24 hours after To the Funaral Dirac completely filled in by	Medical C		ysician: To the bes niner: On the basis and manner s	of examinati								
	To the H within 24 To the Fe complete	M	29b. Signature and title of certifier	m.5			29c. Licens					12, 200.	
			30. Name and address of person who	mo			Print) 111 Penr	n Str	eet	Baltim	ore,	Marylan	nd 21201
	Sta Regist		31. Date filed (Month, Day, Year) MAY 1 8 2		trar's Signat	k A							
DH	MH 17 Rev 1/2		-	100	N. J.	ORIGINA	۸۱	<u> </u>					

			Plea	ase Type or Prii				-	_	ole.	
			For State	State of Ma		epartment of I Certificate of		-	6 U U	5 16	6851
			Registrar  1. Decedent's Name (First, Middle	lle Last)	'	Jertincate of	Death	2. Date of Death	g. No.	3. T	ime of Death
	sicia		RONALD	, 2201/	Ru	E		Month	Day 2		1:17 AM
	edica mine		4a. Facility Name (If not institution	on, give street and number)			or Location of Death		4c. County of		
EXa	111111111	\$1	DORCHESTER	GENERAL	HOSPIT	AL CAM	BRIDGE	-	Do	20 HES	TER
Fune	eral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birtl	nday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year)	9. Birthplace (S	State or Foreign
Direc	_		220-26-1338	15€M 2□F	73 Y	rs. World's Days	110010	Nov. $4$ ,	1931	Maryla	
and *	227		Usual Residence of Decedent  10a. State 10b. County	V	10c. City, Town	or Location				10d. Ins	side City Limits
Maryland -f show		ō		chester			ridge				Yes 2 □ No
28a-		Director	10e. Street and Number			10f. Zip Code	Liage	10	g. Citizen of W	hat Country?	•
death with the	3	٥	1002 Greenwa	y Drive			21613		USA		
death ms 2		Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cub		ecify Yes or No-	14. Race	- American Ind	ian,
after or its	9		1 ☐ Never Married 2 Mar	rried 1 Yes 2	No	1 ☐ Yes 2 🛣 No		riioan, etc.)	Specify:		
15-UU36 (		d by	3 Widowed 4 Divorced	d Year or Dates:						WILLCE	3
127 r	STEE STEE	iete	15. Deceder (Specify only highe	nt's Education est grade completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	a durina most of work	ing 1	6b. Kind of Bus	siness/Industry	
withii than	8	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	estima	•		publ	ishing	
Hygir and The			17. Father's Name (First, Middle,	, Last)	· · · · · · · · · · · · · · · · · · ·		18. Mother's Nam	e (First, Middle, M			
lid be lental		To Be	Phillip H. R	ue			Anna S	mith			
Maryland d 2 should be fill th and Mental H 7 is marked out	Treumatic		19a. Informant's Name/Relations	ship (Type, Print)	19b.	Mailing Address (Stree	t and Number or Run	al Route Number,	City or Town, S	State, Zip Code)	)
C - 10 1			Peggy Rue	wi	The second secon	002 Greenwa			e, MD	21613	
O = = =			20a. Method of Disposition  1   Burial 2 Cremation	3 □Removal from State		Disposition (Name of r, crematory or other pla	ace)	Date 2	0c. Location - 0	City or Town, St	ate
Baltimor permit, Pages Department of Importent: If its	nuò		`4 ☐ Donation 5 ☐ Other (5	Specify)	Salisb	ury Cremato		Control of the Contro	Salisbu		
Balt permit. Departr Importe	any in		21. Signature of Funeral Service	Aicensee		22. Name and Addr		homas Fui			
<b>u</b> ao = 6	8 O		Hou ho	مالام	d the death. Dee		st St., Ca			613	oximate
			23a. Part Enter the disease, o show, or heart failure. Lis	t only one cause on each li	ne.	ot enter the mode of dy	ing, such as cardiac	or respiratory arres	St,	Interv Onse	al Between t and Death
Physici /Medi	_		Immediate Cause (Final disease or condition resulting in death)	a		seal C	ANCER			3	months
Examir				Due to (or as	a consequence o	1):					
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence o	f):					-
cuted	ransır	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> c							
Box 68760, eath certificate be executed attending physician and	uriai-t		resulting in death) Last	Due to (or as	a consequence of	f):					
	a eu	dical		d							
Geath certificate attending physical	se as	Physician/Medio	IF FEMALE:	23c. If yes, outcome	of pregnancy		111,000		024 D-1-	of delivery	
Box auth cert attendin	101 US	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		Mon	of delivery th Day	Year
. 0 0 7	ched	ysic	1 □ Yes 2 🗷 No 9 □ Unknown	9□ Unknown		on onto (speedily)					
i g	deta	by Pr	Part II. Other significant conditi	ions contributing to death t	out not resulting in	the underlying cause g	iven in Part I.	23e. Did toba	acco use contri	bute to the caus	se of death?
rds quires n sign	pg pg							1 ☐ Yes	s 2 No	3 Probably	4 🔲 Unknown
cord  w require  s been sign	short	Completed						24a. Was an	24b. W	/ere autopsy fin	dings available
The lay	age	шо						autopsy perform	ed? de	eath?	
	ŏ	BeC	25. Was case referred to medica	al			26. Place of Deat	h (Check only one			7
Of V Physic	dire	To	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 XInpati	ent 2 ER/Out	patient 3 DOA		ome 5 🗆 Resider	nce 6 Othe	r (Specify)	
ng Pl	Inera		27. Manner of Death  1 Natural 5 Pendi	28a. Date of Inju	ury 28b. T ay Year) Ir	jury Wo		28d. Describe how	w injury occurre	ed	
SiO tendi leath. tor: A	the ft	cati		tigation			]Yes 2 □No	28f. Location (Stre	oot and Numbo	s or Bural Bout	o Alumbor
Division of lor Attending Physalter death. Diractor: After this	n by	Certification:		mined   288. Place of III	jury - At nome, fai tc. (Specify)	m, street, factory, office	•	City or Town,		ii oi nuiai nouli	e ivuitiber,
spital	pell:		29a. Certifier 1⊠ Certifyi	ing Physician: To the best	of my knowledge	death occurred at the	time, date and place,	and due to the car	use(s) and man	ner as stated.	
Division of Vita Vita Within 24 hours after death.  To the Funeral Diractor, After this certification of the Funeral Diractor, and the child of the Child of the	eletely	edical	(Check only 2 Medica one)	al Examiner: On the basis of and manner st		Vor investigation, in my	opinion, death occur	red at the time, da	te and place, a	nd due to the ca	ause(s)
To the To the To the	Comp	ž	29b. Signature and title of certific	er \	- 1		nse number	29	d. Date signed	(Month, Day, Y	'ear)
			/ /woth	2 1. In	rest	MDDE	53 253	MO	04-22	2-05	
			30. Name and address of person		/ /		A=	Para	440	21165	
	0.		31. Date filed (Month, Day, Year	r) 32. Redist	rar's Signature	an	n AVE	PRESTON,	MU	×160)	
Re	Sta gistra		MAY	0 3 2005	Skisa A	San Ball					
		- 2		- 3		7					

Physici /Medic		<ol> <li>Decedent's Name (First, Middle, Last)</li> </ol>				2. Date of Dea		3. Time of Deat
		Edward J.	Randall			APRIL	$29^{\text{pay}}, 2005^{\text{ye}}$	2040 P
Examir		4a. Facility Name (If not institution, give stree SOUTHERN MARYLAND HO		, ,	own, or Location of VTON	Death	4c. County of D	
Funeral Director		5. Social Security Number  031-24-4344  Usual Residence of Decedent	7. Age (In yrs. last	Yrs. If Under 1 Months	Year If Under 2 Days Hours	4 Hrs. 8. Date of Birt (Month, Da		Birthplace (State or For Country) <b>ew York</b>
show	2	10a. State 10b. County		Town or Location				10d. Inside City Lin 1 ☐ Yes 🍇
28a-f	ecto	MD Prince Geo	orge	Oxon Hill	Code		10g. Citizen of What	
Sa or	i D	16 Alexandria Drive	۵.		745		USA	, , , , , , , , , , , , , , , , , , , ,
permit. Pages I and 2 should be lifed within 72 hours are used the mit the manyang Department of Health and Mental Hygiene. Inhiportent: If time 27 le marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Modical Examitment intelliged at an once.	by Funeral Director	11. Marital Status  1  Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1∰Yes 2□No 1959 If es, Give Year or Dates: 1979	13. Was Decede		in? (Specify Yes or No Puerto Rican, etc.)		merican Indian, thite, etc. <b>hite</b>
e. Andrews	Completed	15. Decedent's Educatic (Specify only highest grade co		16a. Decedent's Usual (Give kind of work life. DO NOT use	done during most	of working	16b. Kind of Busine	ess/Industry
Hygien Hygien other th		5	<u> </u>	US Navy	19 Mathe	's Name (First, Middle,	Militar	<b>y</b>
Mental H Merked oth	Be	17. Father's Name (First, Middle, Last)	11				,	
marke	2	Edward P. Randa  19a. Informant's Name/Relationship (Type,		19b. Mailing Address (		therine North Number of Rural Route Number		re, Zip Code)
alth ar 27 le r treu		Donna Randa11/Wii	1			e. Oxon Hi		
item item		20a. Method of Disposition		e of Disposition (Name etery, crematory or oth	of	Date	20c. Location - City	
nent c		1 ☐ Burial 2	05/05/2005 <u>1</u>	Edgewater,MD				
Departr Departr Importe any inju		21. Signature of Funeral Service Licensee  George P. Kalas	Kalas Fu Hill, MD	neral Home 20745				
Chysician  Medical  e attending physician and put as as the burial-transit  d for use as the burial-transit	dicai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequer  Due to (or as a consequer  Due to (or as a consequer	nce of):	7 IO GOLD IN 1			
2 0 0	Physician/Med	in the past 12 months?	If yes, outcome of pregnance    Usive birth   2   Fetal de    Pregnant at time of deat    Unknown	eath 3 Ectopic pre			23d. Date of Month	delivery Day Year
ine death certifically the attending phy ched for use as the	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown					obacco use contribut	
fures that the death certifications in signed by the attending and be detached for use as	by		uting to death but not resulti	ng in the underlying car	use given in Part !.	23e. Did to	\ \	
The law requires that the ste has been signed by th bage 2 should be detache	Completed by	9 □ Unknown  Part II. Other significant conditions contrib  FRACTURED HIP	outing to death but not resulti	ng in the underlying ca		24a. Was autop perfo 1   Yes	an 24b. Were prior grand?	Probably 4 Unknot a autopsy findings availate to completion of cause h?
The law requires that the ste has been signed by th bage 2 should be detache	Be Completed by	9 Unknown  Part II. Other significant conditions contrib  FRACTURED HIP  25. Was case referred to medical examiner?			26. Place	24a. Was autor perfo	an 24b. Were prior deatt 2 No 1 \( \)	Probably 4 Unknown autopsy findings availate to completion of cause h?
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ing Physicien: The taw requires matine  After this certificate has been signed by th funeral director, page 2 should be detache	To Be Completed by	9 Unknown  Part II. Other significant conditions contrib  FRACTURED HIP  25. Was case referred to medical examiner? 1X Yes 2 No  1 Natural investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation.	oital: 1X Inpatient 2 □ EF 28a. Date of Injury (Month, Day Year) 4/28/05 0 28e. Place of Injury - At home	8/Outpatient 3□ DOA 3b. Time of 28 Injury 300 A M	26. Place Other: 4 □ Nur c. Injury at Work? 1 □ Yes 【 □ N	24a. Was autor performed to the state of Death (Check only of Sing Home 5 Residue) Residue of SUBJE	an 24b. Were prior regard? 24ho 3 an 24b. Were prior cheat 1 and 1	Probably 4 Unknot a autopsy findings availate to completion of cause h?
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'nyeicien: The law fequires mat me this certificate has been signed by th al director, page 2 should be detache	Be Completed by	9 Unknown  Part II. Other significant conditions contrib FRACTURED HIP  25. Was case referred to medical examiner?  1X Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation investigation investigation determined  2X Accident 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physicia (Check only 2 X Medical Examiner:	Dital: 1 Inpatient 2 EF  28a. Date of Injury (Month, Day Year)  4/28/05  28e. Place of Injury - At home building, etc. (Specify)  an: To the best of my knowlet: On the basis, f examination	NOutpatient 3 DOA 3b. Time of 28 Injury 300 A M e, farm, street, factory, HOSPITAL edge, death occurred an and/or investigation, i	26. Place Other: 4 □ Nur c. Injury at Work? 1 □ Yes 🏋 □ N office	24a. Was autor performed to the control of the cont	an 24b. Were say med 24b. Were say med? 24b. Were prior med? deatt 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Probably 4 Unknown autopsy findings availate to completion of cause how the second sec

			For State Registrar	State of M	faryland.	/ Depa	artment <i>rtificate</i>	of H	ealth a Death	and M		jienę) ( eg. No.	05	16853
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		William_	Sm	ith						May 1,	2005	1001	8:15 A M
	Examin		4a. Facility Name (If not institution,		r)		4b. City, T	own, or	Location	of Death		4c. Cou	nty of Death	
			Prince Georges				Che	ver1	y If Under	24 Hes			nce Ge	
П	Funeral		,	5. Sex 7. A 1X M 2 ☐ F	nge (In yrs. last	r birtngay) Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
	Director		243-20-5684 Usual Residence of Decedent		80					l	10/18/	1924		NC
	yland		10a. State 10b. County	_	10c. City, T									10d. Inside City Limits
	a-fa	ctor	Maryland Prince	Georges	Nev	√ Car	rollto	on						1 □XYes 2 □ No
	th with the 23a or 28	ai Director	10e. Street and Number 8424 Ravenswood	Road			10f. Zip (	0784			1	0g. Citizen o USA	of What Cou	ntry?
980	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be nutilised at	by Funerai	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces d 1 Tyes 2 if Yes, Give Year or Dates	s? <b>}</b> No		Was Decede f Yes, speci 1 ☐ Yes 2	fy Cubar	spanic Ori n, Mexicar Specify:	n, Puerto	ecify Yes or No- Rican, etc.)	E	Race - Ameri Black, White, cify: Bla	etc.
Ö	2 ho	ted	15. Decedent's (Specify only highest		1	16a. Dece	dent's Usual kind of work	Occupa	tion	et of work	ina	16b. Kind of	Business/Ir	dustry
215	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	r 5+)	life.	DO NOT use sician	e retired)	uning mos	i or work	ing			
21	filed wi Hygien other th			2									Emp1c	yed
Maryland 21215-0036	2 should be filed and Mental Hygi is marked other aumatic event, II	To Be	17. Father's Name (First, Middle, La Rogers Smith	as()					Ze.	lla l	e (First, Middle, i Bryant	Maiden Sum	ame)	
	ges 1 and 2 should t of Health and Men If Item 27 is marke or other traumatic		19a. Informant's Name/Relationshi Irma Smith - Wi								al Route Number  V Carrol			
nore,	ages 1 and 2 nt of Health t: If Item 27 i y or other tre		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		e cem	etery, crei	sition (Nam natory or oth	her place			Pate 4/2005		n - City or T	
Baltimore,	permit. Pages Department of H Important: If Ite any injury or of	İ	21. Signature of Funeral Service Li		FOIL	22	2. Name and	Addres	s of Facili	ty Fo	ort Line	oln Fl		
	40100		23a. Part1. Enter the disease, or c	omplications that cause	ad the death. I						Rd; Bren		MD 20	Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each	line. Renal				,,					Interval Between Onset and Death 24 Hours
	/Medical Examiner		resulting in death)		s a consequen									
Ы		<u></u>	Sequentially list conditions,	D	ary Art		Diseas	se						7 Years
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 t0 (01 a	a consequen	100 01).								
	ate be executed hysiclan and the burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or a	s a consequen	ice of):								
8760,	siclar b buri	dical E		d										
.89	ificate g phy as the	(a) +		V.										
.O. Box	the death certificate be executed y the attending physician and ached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal de at time of deatl	ath 3[	Ectopic pre Other (spe						Date of deliv Month	ery Day Year
σ.	es that igned b	þ	Part II. Other significant condition Diabetes Mell		but not resultin	ng in the u	nderlying ca	use give	n in Part I					he cause of death?
ecords	requ	etec	<b>C1 L C1</b> .											
$\mathbf{\alpha}$	The lay ate has page 2	Completed	Chronic Obstr	uctive Lung	g Disea	se					24a. Was a autops perform	SV SV	prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available impletion of cause of
of Vital	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	2							(Check only on			
₹	S S D	2	1 Yes 2 No	Hospital: 1  Inpat	42		t 3□ DO/				me 5 ☐ Reside			(y)
on o	Jing After fune	ation;	27. Manner of Death  1	28a. Date of In (Month, D	jury 28 Day Year)	Bb. Time o Injury	M 28	lc. Injury Work 1 🔲 Y	at ? ′es 2 □		28 <b>d. Des</b> cribe ho	ow injury occ	curred	
Division	or A lifter Jirec in by	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 200. Place of I	njury - At home etc. <i>(Specify)</i>	e, farm, str	eet, factory,	office			28f. Location (Si City or Town	reet and Nu n, State)	mber or Rur	al Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C		Physician: To the bes xeminer: On the basis and manners	of examination									
	To the To the Comple	Mec	29b. Signature and title of certifier	0 1/1				-	number			9d. Date sig	ned (Month,	Day, Year)
			) X. /	Kontil	1		1	16	24	ਰ /	UD	3/	2/6	77
R	(5)		30. Name and address of person w Revathy Murthy	ho completed cause of 6130 Land				7 MD	2078	35				
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 2	2 Posis	strar's Signature			<del></del> -						

			1 - For State Registrar	State of M	Maryland /	•	artment rtificate			and M		giene	005	16854
			Decedent's Name (First, Middle	, Last)	·						2. Date of Dea	ith		3. Time of Death
	Physici		Robert L.	Scales							May 2, 2	005 Day	Year	10:52 A M
	/Medic Examin		4a. Facility Name (If not institution	, give street and number	er)		4b. City, 1	own, or	Location o				County of Death	
			Prince Georges	Hospital Cent	er			Cheve	erly			Pri	ince Geor	ges
	Funeral		5. Social Security Number		Age (In yrs. last i		If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth Cou	place (State or Foreign untry)
	Director		233–28–0172	1☐XM 2☐ F	86	Yrs.					Sept 20,	1918		inia
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	ocation							10d. Inside City Limits
	fanyi f sho	ō	MD Prince	e Georges		Col	mar Man	or						1 X Yes 2 ☐ No
	the t	Sec.	10e. Street and Number				10f. Zip					10a. Citizo	en of What Cou	untry?
	3a or	Funeral Director	3405 40th Aver	ni 10-			2	0722				-	J.S.A.	•
	ms 2	era	11. Marital Status	12. Was Decede		13.			spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		4. Race - Amer	
9	after or Ita	Ē	1 Never Married 2 Marri	Armed Force	s? <del>X</del> No	ì	ir ves, speci 1 □ Yes 2		Specify:	i, Puerto i	rican, etc.)		Black, White Afr	o, etc. ican
8	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Examination and the modified at	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	s:		10.163 2		эреспу.			3	Specify: Ame	erican
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	a filed y Il Hygie other I		17. Father's Name (First, Middle,	Last)		Coar	Minor/	Store			(First, Middle,		Private	
an	Mental Mental arkad o	o Be	Frank Scales							nie Ke			,	
Maryland	should be and Menta Is marked sumatic ev	2	19a. Informant's Name/Relations	nip (Type, Print)	1	9b. Maili	ng Address	(Street a			l Route Numbe	r, City or	Town, State, Zi	ip Code)
	C1 (G W E		Sharon Scales- I	aughter	(	5032 1	West Ch	ester	Park	Driv	e Apt T2	Co11	lege Park	MD 20740
Ē,	es 1 and 2 of Health I item 27 I		20a. Method of Disposition		20b. Place	of Dispo	sition (Nam	e of her place	a)	D	ate	20c. Loc	ation - City or T	Town, State
E	Page nent c int: If		1 XBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)		10		1n Černe			5/10/	05	Brent	wood, MD	)
Baltimore,	permit. Pages Department of I Important: If its any injury or ot		21. Signature of Funeral Service	Licensee	The state of the s						Lincoln			
<u>—</u>	20 5 5 3					3	401 Bla	denst	ourg Ro	oad 	Brentwoo	d MD 2	20722	
г			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	sed the death. D	o not ent	ter the mode	of dying	, such as	cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death
	Fnysician		Immediate Cause (Final disease or condition	_a Acuto	e Myo	Curi	dial	In	rarc	Lion	6			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequenc	e of):	W	1	14	-				
		-	Sequentially list conditions, if any, leading to immediate	b. Acu	le 1	Ken	CI	r c	ulu	ve				
	ted nsit	nin	cause. Enter Underlying Cause (Disease or injury	5,0	OC SC	~ OI).								
Ć,	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or	as consequenc	e of):								
8760,	death certificate be executed e attending physician and d for use as the burial-transit	ical		d										
9	tificate g phys as the	edi		T								- 100		
Box	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 DFetaf dea	ıth 3.⊡	∃Ectopic pre	anancy				23	3d. Date of deliv	,
	ie deat the att	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		Other (spe						Month	Day Year
P.0	÷ > 0	Phy	9 Unknown								60 5:44			
	Se do es	by	Part II. Other significant condition	ins contributing to death	n but not resulting	j in the u	nderlying ca	use give	n in Part I.			es 2 🗆		the cause of death?
oro	w requir been si should I	eted									-			
Records,	e law has b	Completed									24a. Was a autop	SV	24b. Were aul prior to co death?	opsy findings available ompletion of cause of
	iclan: The certificate ha										1 Yes	2 No	1 ☐ Yes	2 No
Vital		o Be	25. Was case referred to medical examiner?	Hospital:	, a = 0 = 0.	0		Othe	NP.		(Check only or		T0.11 (2)	
of		<b>-</b>	27. Manner of Death	28a. Date of Ir	niury 28b	. Time o		Bc. Injury Work			ne 5 🗆 Resid			ity)
ion	E & B	atlor	Natural 5 ☐ Pendin 2 ☐ Accident investig	9	Day Year)	fnjury	м		? ′es 2 🔲 !	No				
Division		ifica	3 Suicide 6 Could r	aned 286. Place of	Injury - At home, etc. (Specify)	farm, sti	reet, factory,	office		2	8f. Location (S City or Tow		Number or Rui	ral Route Number,
Ö	tal or	Certification;	T I TOTAL OC	Danaing,	otc. (Specify)						0119 07 7 011	ri, Oldio,		
	e Hospital 24 hours a a Funaral I	edical	(Check only 2 Medical	g Physician: To the be Examiner: On the basis	of examination	lge, deat and/or in	h occurred a vestigation,	it the tim	e, date an	d place, a	nd due to the o	ause(s) a	and manner as	stated. to the cause(s)
	the tha tha	Med	one) 29b. Signature and title of certifier	and manner	stated.		29c.	License	number			29d Date	signed (Month	Day Year)
)	or T with		MSA	UNIX MID	) .		1	)4 FC	304	2_		5/0	2/7	005
	P15		30. Name and address of person	-148,		a) (Type	Print)	-				- 1	- 1000	
C	100		Mohammad	Sarfara		219	Sui	te	13	Cire	een be	it	Mur	yland.
	Sta		31. Date filed (Month, Day, Year)	■2. Regi	strar's Signature									
	Registr	ar	MAY 0 5 21	JUJ COM	J 18 1	900								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 1:15AM May 2005 Billie Marie Sowards /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rising Sun

If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Day, Year) Calvert Manor Healthcare Center Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 2 F Months October 24,1923West Virginia 81 Director 236-36-4842 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow event, the Mudical Examiner must be notified at 1X Yes 2 No Directo Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or iteme 23s 128 Gracecroft Drive 21078 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify. White 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced "neturel", Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home other 1 permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: if item 27 is marked oth eny injury or other traumatic event size. 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alta Mae McCloud 2 James Kehoe Peters. Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 128 Gracecroft Drive Havre de Grace MD 21078
of Disposition (Name of Date 20c. Location - City or Town, Stete Mary Foughkeepsie/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State May 5,2005 Dock's Creek 4 ☐ Donation 5 ☐ Other (Specify) Kenova, West Virginia 21. Signatur Funeral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 South Queen St., Rising Sun, MD 21911 23a Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration **Physician** Week /Medical Due to (or as e consequence of): Examiner Week Due to (ons a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physicien as Box 68760, Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Wisheimen's 1 ☐ Yes 2**X**No 3 Probably 4 Unknown as been signal Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other 2 4 Qursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending To the nospector within 24 hours after death.

To the Funerel Director: At 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Dey, Year) D0058354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Lattin, MD 101 Colonial Way, Rising Sun, MD 21911 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAY - 5 2005

		1 - For State Registrer	State of N	Marylar		artment rtificate				Reg. No	2000	16856
Physici	an	1. Decedent's Name (First, Middle							2. Date of I	Da		3. Time of Death
/Medi	cal	ELEANOR  4a. Facility Name (If not institution	J.	ar)	SEAS		own, or Loca	tion of Deat	APRIL	30	2005 County of Deat	11:00 A <sup>M</sup>
Examir	ner	PRINCE GEORGE'S		~,			CHEVER				RINCE GI	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday)	If Under 1	Year If U	nder 24 Hrs				hplace (State or Foreign untry)
Director		233-32-2408	1 □ M 2 🕱 F	82	Yrs.	Months I	Days Ho	ours Min.	Septe			bama
and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
Maryli f sho	ŗ	MD Designation	Caamaala	Lar	Jamas							1 <u>√</u> Yes 2 □ No
ith the Marylan or 28e-f show	Director	MD Prince  10e. Street and Number	George's	Lal	ndover	10f. Zip C	ode			10g. Ci	tizen of What Co	untry?
th with	al D	9200 Beth Aver	ue			207	785				U.S.A.	
r dea	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U s?	l.S. 13.	Was Deceder	nt of Hispani y Cuban, Me	ic Origin? (S exican, Puer	Specify Yes or Note of to Rican, etc.)	10-	14. Race - Ame Black, White	
rs afte	by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 { If Yes, Give Year or Date:	-		1 ☐ Yes 25	No Spe	ecify:			Canaifu	ack
be filed within 72 hours after death with the Maryland ital Hygiene.  do other than "natural", or itams 23a or 28e-f show event, the Medical Evantrar must be notified at		15. Deceden	's Education			dent's Usual (				16b. K	(ind of Business/	
hin 72	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4c	or 5+)	(Give life.	kind of work DO NOT use	done during retired)	most of wo	rking			,
of the	E O	Liomontary/Goodinatry (G 12)	4 yı		S	choo1	Teach	er		Go	vernmen	t
and yidailor 2.12. 2 should be filed within and Mental Hygiene. Is marked other than is umetic evant, the Mental Control of the Mental of the	Be (	17. Father's Name (First, Middle,	Last)						me (First, Midd		Sumame)	
2 should be and Mental is marked or aumetic ever	၉		ett						ia Step			
d 2 sh d 2 sh dh and 7 is n traum		19a. Informant's Name/Relations Tillman R. Sea			19b. Mailii 2002	ng Address (S <b>Parksi</b>	Street and N L <b>de Dr</b>	ive M	ural Route Num itchell	ber, City ∈ Ville	or Town, State, 2	and 20721
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumetic once.		20a. Method of Disposition		20b. I	Place of Dispo	osition (Name	of	1-1-1	Date		ocation - City or	
Pages ent of ry or o		1 ■Burial 2 □ Cremation  4 □ Donation 5 □ Other (S		10	cemetery, crei Linco	-		5/6	/05	Brei	ntwood,M	arvland
mit. F partm sortar / injur		21 Signature of Funeral Service									Funera	
Depa Depa Impo any it	1	16			10.7	7474 La	indove	r Roa	d Lando	ver,	Marylan	d 20785
Physician /Medical Examiner picture and pringiple in a pringiple in a pringiple in a principle i	Examiner	23a. Part 1. Enter the Jisease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or co.	as a consecutation as a consecut	quence of):				c or respiratory		ease	Approximate Interval Between Onset and Death
ath certificate	Physiclan/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	2 Feta	aldeath 3□	□Ectopic preg □ Other (spec					23d. Date of deli Month	very Day Year
w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions Stape 4 A	ens contributing to death	but not res	sulting in the u	nderlying cau	se given in F	Part I.				the cause of death?
The law re rate has bee page 2 sho	Completed								24a. Wa aut per 1 🗆 Yes	opsy formed?	prior to death?	topsy findings available completion of cause of
ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:				Other		ath (Check only			
Phys this	- To	1 Yes 2 No	28a. Date of Ir		ER/Outpatier 28b. Time of			Nursing H	lome 5 Res		6 Other (Spec	sify)
ding f h. After funer	tlon	1 Natural 5 Pendin 2 Accident investig	g (Month, l	Day Year)	Injury	м 200	lnjury at Work? 1 ☐ Yes	2 □ No	Zod. Doscribe	3 110W III Ju	ry occurred	
el or Attano s after death il Director: id in by the	Certification:	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of	Injury - At h etc. (Specil	ome, farm, str fy)	reet, factory, o				(Street ar own, State		ral Route Number,
To the Hospitel or Attancii within 24 hours after death. To the Funaral Director: A completely filled in by the fu	edical	29a. Certifyin (Check only one)  1  Certifyin 2  Medical	g Physician: To the be Examiner: On the basis and manner	of examina	owledge, death ation and/or in	h occurred at vestigation, in	the time, da my opinion	te and place, death occu	e, and due to the arred at the time	e cause(s e, date an	) and manner as d place, and due	stated. to the cause(s)
To t To t	Σ	29b. Signature and title of certified	00 0	11.1		29c. L	icense num				te signed (Month	
		Stuck	ellende	Ni	m	< 0	013	7 3		30A	PEIZ Z	005
- (0)		30. Name and address of person	who completed cause o	f death (Iter	n 23a) (Турө, Ри <i>еек</i>	Print) US bur	y Rd	Hya	Houle	e M	1 20	781
Sta Registi	100	31. Date filed (Month, Day, Year)	2. Regi:	strar's Signa	ature	w						

			For State Registrar	State of Maryland /		of Health and Me of Death	lental Hygien	6002	16857
	Physicia	_	1. Decedent's Name (First, Middle, Las. ALCX T	Tingle	2		2. Date of Death	ay Year 1 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give BALT-mcRe VA	MediCAL CEN	HER BA	Town, or Location of Death Linure		c. County of Death	
	Funeral Director		5. Social Security Number  6. Se  11  Usual Residence of Decedent	7. Age (In yrs. last	birthday) If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp Cour 955 Ma	place (State or Foreign http) YY/and
P	ith the Maryland or 28a-f show	ctor	10a. State 10b. County  MD Queen	A .	own or Location	ille		1	0d. Inside City Limits 1 ☐Yes 2 ☐ No
R	ath with the 23a or 28	Funeral Director	100. Street and Number 1109 - Cemeter	y Road P.O.Bo	10f. Zip	21638		Citizen of What Cour	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hyglene. Important: If item 27 is markad other than "natural", or Itams 23a or 28a-1 show any injury or othar traumatic event. Ite Medical Examinet must be notified at once.	þ	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	h2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1976 If Yes, Give Year or Dates: 1979	/	ent of Hispanic Origin? (Sperify Cuban, Mexican, Puerto	ecity Yes of No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	within 72 ho ine. ihan "natur in Medical I	Completed	15. Decedent's Ed (Specify only highest grad		6a. Decedent's Usua (Give kind of wor life. DO NOT us	k done during most of work e retired)	ing 16b.	Kind of Business/In-	dustry
land 2	td be filed v ental Hygie kad other I ic event, tt	To Be Co	17. Father's Name (First, Middle, Last)	Leroy T	inale		First, Middle, Maide	en Sumame)	Uriaht
, Maryland	and 2 shou raith and M raith and M raith and mar raith ar traumat	-	19a. Informant's Name/Relationship (19a)	ypo, Print)	19b. Mailing Address	(Street and Number or Rure	al Route Number, City Grasonv	ille, MI	21638
Baltimore,	Pages 1: ment of He ant: If ften jury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  1 ☑ Donation 5 ☐ Other (Specify	Removal from State	e of Disposition (Nametery, crematory or of	netery 3/		Location-City or To	nary land
Ball	permit. Depart Import any in		21. Signature of Funeral Service Licen	C. Henry	HENRY	ashing ton s	tome, P.A.	ridge, M	Dr 21613 Approximate
	Physician (		23a. Part 1 Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Bilateral  Due to (or as a consequen	1 phe	mon ja	or respiratory arrest,		Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequent					
760,	ate be axecuted hysician and he burial-transit	cal Examiner	cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequen	ice of):				
89	leath certificate attending phys I for use as the		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of delive	ery
.0. Box	that the death ed by the atter detached for u	Physiclan/Med	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown				Month	Day Year
ords, P	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	by	Part II. Other significant conditions of	ontributing to death but not resultin	ng in the underlying c	ause given in Part I.	23e. Did tobacc	o use contribute to to	
Division of Vital Records,	The law racate has be page 2 sh	Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	VO.4	Othor	h (Check only one)	0 Flother /00-1	£.1
of	ding Phys h. After this funeral di	n: To	1 ☐ Yes 2 No 27. Manner of Death		VOutpatient 3 DC  Bb. Time of 2 Injury		me 5 ☐ Residence 28d. Describe how in		<i>y</i> /
sion	Attanding ir death. actor: After by the fune	atlo	1 Natural 5 Pending 2 Accident investigation		М	1 ☐ Yes 2 ☐ No			
Divis	oital or Attandir urs after death. ral Diractor: Af lled in by the fu	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify)			28f. Location (Street City or Town, Sta	ate)	
	Hospital     24 hours a     Euneral istely filled	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	and/or investigation	, in my opinion, death occur	red at the time, date a	and place, and due to	o the cause(s)
	To the Hospital c within 24 hours at To the Funeral D completely filled in	Me	29b. Signature and title of certifier	u	290	License number LISIYY REONESTR	29d. I	Date signed (Month, $5/1/2$ 00	Day, Year)
_			30. Name and address of person who		3a) (Type, Print)	REONE STR	eet BA	itimore,1	402124
	Sta	ite	31. Date filed (Month, Day, Year)	2005 32, Registrar's Signature	M Shoul	Ž te			

			1 - For State Registrar		laryland / [		artment tificate			and M	R	eg. No.	105	5	958
	Physici	an	Decedent's Name (First, Middle, )	_							2. Date of Dea Month May 2,	Day -	Year	3. Time of	
	/Medic	ai	Shannon A				41 67 7		1	10	May 2,			8:46	ам
1	Examin	er,	4a. Facility Name (If not institution, s Southern Maryla					ntor	Location o	or Death			ty of Death	eorges	
	Funeral				ge (In yrs. last bir	thday)	If Under	1 Year	If Under:		8. Date of Birth				or Foreian
	Director		579-13-2242	1□M 2 <b>Ğ</b> F		Yrs.	Months	Days	Hours	Min.	Nov. 18	Year) 1981	Wasi	place (State on htry) ningtor	ı,D.C
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Lo	cation							0d. Inside Ci	ity Limits
	Many -1 ah	ē	Maryland Prince	Georges	Upper	Ма	r1hor	·0						1 <b>½</b> Yes	2 🗌 No
	r 28a	Director	10e. Street and Number	Georges	оррог		10f. Zip				1	0g. Citizen o	f What Cou	ntry?	
	th with	a D	9607 Rose View C	Ct.			20	772				Unit	ed Sta	ites	
	ams ams	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. V	Vas Decede	ent of His	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		ace - Ameri		
36	be filed within 72 hours after death with the Maryland stal Hyglene. Id other then "netural", or Itams 23a or 28a-f ahow evant, I're Madical Evariner must be notified at	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		I□Yes 2				, ,		ify: B1		
21215-0036	2 hou etura	ted	15. Decedent's	Education	16a.	Deced	lent's Usual	Occupa	ition			16b. Kind of	Business/In	dustry	
215	within 7 ene. then "n he Med	Completed	(Specify only highest (Specify only highest	<i>grade completed)</i> College (1-4or	5+)	life. L	kind of work DO NOT use	k done d e retired)	uring mosi	t of work	ing				
2	filed wi Hygien thar th	Con	12			Di	sable	<u>d</u>				None			
and	d be fil ental H ced otl	To Be	17. Father's Name (First, Middle, La Steven Turner	st)							e (First, Middle, i Alstoi		ame)		
Maryland	ges 1 and 2 should be it of Health and Mente if itam 27 la marked or other treumetic e	۲	19a. Informant's Name/Relationship								al Route Number				
	is 1 and 3 of Health itam 27 other tr		Linda Turner /	Mother					3.2		er Marll Date	20c. Location		20772	
Mor	Pages nent of H int: If its		1 → Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Spe		20b. Place of cemeter Harmo				1	-9-0		Landov			
Baltimore,	Department Important: any injury once.		21. Signature of Funeral Service Lic		101 nex	22 A	Name and 1exan	d Addres	s of Facilit	бре	Funeral	Homes	, P.A.		
			23a. Part1. Enter the disease, or co	emplications that cause	d the death. Do r						/Foresty		Md.	20747 Approximate	в
	Pnysician		shock, of heart failure. List or Immediate Cause (Final	ly one cause on each	ine.	g		3000						Onset and D	Death
	/Medical		disease or condition resulting in death)	a Due to (or as	a construence	of):	con	000	1	mo,	nea		- 6	mkn	own
В	Examiner		Sequentially list conditions	b C	nek	-	P1.	Da	by				4	m Kno	ار ساد
	P ::	Iner	Sequentially list conditions, if any, leading to kinn offatte cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as	sa dunsaquendo :	.f)	1	a) .							
	and and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	77/	0	165	ION					-	m Hno	, w.
8760,	ate be executed hysician and the burial-transit	calE				,,.									
687	ficate p physis the			d.											
Вох	death certifice e attending ph ed for use as ti	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			In					23d. D	ate of delive	ery	
	death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 □ Fetel death it time of death		Ectopic pre Other (spe					N	lonth	Day Y	/ear
P.0	that the de ned by the a detached f	Phys	9 Unknown												
	ires tha signed I be det	by	Part II. Other significant conditions	s contributing to death I	but not resulting in	the ur	nderlying ca	iuse give	n in Part I.			oacco use co os 2□No		ne cause of di ably 4 📶 U	
ecords,	law requires as been sign 2 should be	eted													
Rec	9 - 9	Completed									24a. Was a autops perforr	y	. Were auto prior to co death?	psy findings a apletion of ca	available ause of
g	ician: Th certificate rector, pag	e Co	25. Was case referred to medical						00 Pl	-f D41		16	1 Yes	2 No	
Vital	Physician: this certificatal director.	0 B	examiner?	Hospital:	ent 2 ER/Ou	Ination:	t 3 🗆 DO	Othe			n <i>(Check only on</i> me 5 ☐ Reside		that (Specif	vl.	
		± iu	27. Manner of Death	28a. Date of Inj (Month, Da	ury 28b. T	ime of		Bc. Injury Work		7	28d. Describe ho			·/	
jor	Attanding in death.	atio	1	ion	1) (647)	цигу	М		'es 2 □ i	No					
Division	II or Attand after death   Director: / d in by the f	Certification;	3 Suicide 6 Could not 4 Homicide determine	200. Flace UI III	jury - At home, far tc. (Specify)	rm, stre	eet, factory,	office			28f. Location (St City or Town		ber or Rura	l Route Numi	ber,
	Hospital 4 hours a Funaral E tely filled i		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge	dosth		.6.61		d alaaa	and due to the co			late of	
		edical	(Check only 2 Medical Ex	Physicien: To the best aminer: On the basis and manners	of examination and	dor inv	estigation,	in my op	inion, deal	th occurr	ed at the time, d	ate and place	, and due to	the cause(s)	J
	To tha within 2 To tha comple	Me	29b. Signature and title of certifier	/ .			29c.	License	number		2	9d. Date sign	ed (Month,	Day, Year)	
			Ant Jul	allm,	nO		50	04	54		n	ray,	3,2	005	
(	122		30. Name and address of person wh				,	, .		357					
	Sta	te	Arastoo (Mazda 31. Date filed (Month, Day, Year)	32 Regist	Suite 35 rar's Signature	U F	t. Wa:	snin	gton	, Md	· ZU/44	<del></del>			
	Registr		MAY 0 5 2		· K,	de s	Les .				,				

					d / Department of F		-	•	
			1 - State Registrar	ate of marytar	Certificate of		Reg. N	ZUIIS	16859
	Dhysisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month D		3. Time of Death
	Physici /Medio		Howard Tau	1100			5 1	2005	1047 M
	Examin	er	4a. Facility Name (If not institution, give stree	A . ( 1 /	4b. City, Town, o	r Location of Death		County of Death	200
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth	9. Birth	place (State or Foreign
ľ	Director		342-01-3860 120	2LIF 95	Yrs. World's Days	Hours Will.	(Month) Dayi Yea	59 III	inois
	low low		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location				IOd. Inside City Limits
	Ba-fel	Director	MD Wiconi	co Sa	lisbury				1 yes 2 No
	d within 72 hours after death with the Maryland jiene. Ir then "naturelt, or Itams 23e or 28e-f ehow Its Modical Examirer mast be notified at		10e. Street and Number	11/02	10f. Zib Code	201		itizen of What Cou JSA	ntry?
	death ms 23	Funeral		Vas Decedent Ever in U	S. 13. Was Decedent of H	lispanic Origin? (Spec		14. Race - Ameri	
9	or Ita		1 Never Married 2 Married 1	Armed Forces? ☐Yes 2 [X]No fYes, Give	1 Yes 2 1 No	an, Mexican, Puerto H Specify:	ican, etc.)	Black, White,	11 0
Ö	turel',	ed by	3	ear or Dates:	16a. Decedent's Usual Occup		165	Kind of Business/Ir	
215	within 72 ene. then "na!	Completed	(Specify only highest grade cor	inpleted) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of working d)	9	WIG OF DUSITIOSS/II	dustry
Maryland 21215-0036	illad with Hygiene. other the	Сош	12	1	Steam Fitter			umbing	
and	d be fill hall Had oth	Be	17. Father's Name (First, Middle, Last)  Samuel Taylor				(First, Middle, Maide Dara Nevi]		
ary	s 1 and 2 should be fillar f Health and Mental Hyg item 27 is markad otha other treumatic event,	5	19a. Informant's Name/Relationship (Type, I	Print)	19b. Mailing Address (Street				Code)
	1 and 2 Health a tem 27 is		Sam Taylor/son		3763 Villag			MD 2186	3
Baltimore,	0 0		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Remo		Place of Disposition (Name of semetery, crematory or other place	ca) Da	te 20c. I	ocation - City or To	own, State
ij			' 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Lic 1's e	S	niloh Cemetery 22. Name and Addre	5/8/05	10000	loh, IL	
Ba	parmil. Departr Importe any inji		> Hit R Low	ly (FSD	Holloway	Funeral Ho Hill Rd.,	me Profes	sional A	ssociation
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	one that caused the deat	h. Do not enter the mode of dyir	ng, such as cardiac or	respiratory arrest,	1 PD 210	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Asovo				Sycars
П	Examiner			Due to (or as a conseq	uence of):				8
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Charles or it, if y that initiated events c.	Due to (or as a conseq	uence of):				
	be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	Hence of):				
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68	leath cartificat attending phy i for use as the	edi	IE EENALE.						
Вох	ath ca ttendii	ian/N	in the past 12 months?	f yes, outcome of pregna □ Live birth 2 ☐ Feta	Il death 3 Ectopic pregnanc	1		23d. Date of deliv Month	ery Day Year
O.	that the de ned by the a detached f	Physician/M		I□Pregnant at time of d □□Unknown	leath 5 ☐ Other (specify) _		- "		
Д.	The law requires that the death cartifica te has baen signed by the attending ph tage 2 should be detached for use as th	by Pi	Part II. Other significant conditions contribu	iting to death but not res	ulting in the underlying cause given	en in Part I.	23e. Did tobacco	use contribute to t	ne cause of death?
ord	w require baen sig should b						1 ☐ Yes 2	No 3 Prol	pably 4 Unknown
Records,	e law I has bu je 2 sh	ompleted					24a. Was an autopsy performed?	24b. Were auto prior to co death?	psy findings available mpletion of cause of
Vital		e Co	25. Was case referred to medical			26. Place of Death	1□ Yes 2 N	o 1 ☐ Yes	2 No
Ĭ Vi	nyeici nis cer direc	To B	examiner? 1 Yes 2 No Hosp	tal: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 □ DOA Oth	er: 4 Nursing Hom		6 Sther (Specia	y) Assisted I
on of		lon:	1 ☑Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wor	y at 28 k?	3d. Describe how inju	ury occurred	Living
Division	at at	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	Be. Place of Injury - At h	ome, farm, street, factory, office	Yes 2 □No	Bf. Location (Street a		il Route Number,
Ö	s after al Dire	Certification:	4 Homicide	building, etc." (Specil	y)		City or Town, Sta.	'e)	
	To the Hospitel or Attu within 24 hours after de To the Funeral Direct completely filled in by th	edical	(Check only 2 Medical Examiner:	On the basis of examina	owledge, death occurred at the til ation and/or investigation, in my o	me, date and place, ar pinion, death occurred	nd due to the cause( d at the time, date ar	s) and manner as s nd place, and due t	tated. o the cause(s)
	ithin 2 o the	Med	29b. Signature and title of certifier	and manner stated.	29c. Licens	e number	29d. D	ate signed (Month,	Day, Year)
)	F S F O		> mle Nata	DR.U-M	HTESAN DOS	7359	Ma	in 2 kd k	005
			30. Name and address of person who comple	eted cause of death (Iter	n 23a) (Type, Print)		10	1	
	CA	10	DR. USHA NATES AN 31. Date filed (Month, Day, Year)	1415 - S 32. <b>B</b> gistrar's Signa	DOS n 23a) (Type, Print) DIVIS ION ST, ature	SALISBY	ky mo y	804	
	Sta Registi		MAY 0 4 2005	Blow.	D. Sparke				

KENDRICK T. ADAMS 05-3051

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] 5 686 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2, Day 2005 Year MAY **Physician** KENDRICK TIRRELLADAMS 1520 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RT. 425 & POSEY GRAY PLACE Marbury CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) **XX**M 2□ F 577-96-1593 Director 36 APRIL 26, 1969 MARYLAND Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "netural", or items 23e or 28e-f show the Madical Exemple must be multied at 1 TYes 2 □ No Funeral Director MD CHARLES WALDORF 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11545 LELAND PLACE 20601 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after Yes 27 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ELECTRICIAN ELECTRICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental F is marked of JAMES ARTHUR PROCTOR JOANN SHEILA ADAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ent: If item 27 is ANGEL ADAMS / WIFE 11545 LELAND PLACE, WALDORF, MD 20601 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or permit. Page Department of Importent: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ST. JOSEPH'S CEMETERY MAY 9, 2005 POMFRET, MARYLAND 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MD
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Immediate Cause (Final) 21. Signature of Funerati Servi Approximate Interval Between Onset and Death Immediate Cause (Final Physician Multiple MILLIES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2 \[ \] No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1x Yes 2□ No Other: 4 Nursing Home 5 Residence Other (Specify) SCENE this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending 3:10 0 1 ☐ Yes 2 🕱 No motoreyelist Involved in collision death. investigation 5/2/05 the Director: 28f. Location (Street and Number or Rural Route Number City or Town, State) 14-425 Childy Syry PACE 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined after ö STVEET

WAYBUY MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a 29a, Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCME MAY 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 1 TUS, MID M. JACK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 5 2005 Registrar

		1 - For Unpend Item 2:	State of Marylan 3a,27,28a-1 pe	d/Depa er me Cei	artment of H 1843 5-16 tificate of I	lealth a -05 ta Death	nd Mental Hy is	/giene Reg. No. 200	5 16862
Physic	ian	1. Decedent's Name (First, Middle, Last	)				2. Date of D	eath Day Yea	3. Time of Death
/Med			ee Willey				May 7	, 2005	10:10 P M
Exami	ner	4a. Facility Name (If not institution, give	,		4b. City, Town, or	Location of	Death	4c. County of D	eath
Supere	7	Easton Memorial H  5. Social Security Number 6. Se		last birthday)	Easton If Under 1 Year	If Under 2	4 Hrs. 8. Date of Bi	Talbot 9.1	Birthplace (State or Foreign
Funeral Director			DM 2□F 44	Vrc	Months Days	Hours	Min. 8. Date of Bi (Month, D		Country)
) P		Usual Residence of Decedent  10a. State 10b. County	100 Cit	y, Town or Lo	antion				
h the Marylander 28a-f show	ō								10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the A 28a-f	Director	Maryland Caro  10e. Street and Number	oline D	enton	10f. Zip Code			10g. Citizen of What	
5-0036 72 hours after death with the Maryland netural; or Items 23e or 28e-f show alsel Examine at must be notified at		900 Market Stre	a t		2162	Q		United S	tates of
death	Funeral	11. Marital Status	12. Was Decedent Ever in U.				in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - A Black, W	America merican Indian,
36 after or It.	by Fu	1 Never Married 2 Married	1 Styles 2 □ No 19	78-		Specify:	1 30.10 1 1100.1, 010.1	Specify:	rine, etc.
5-0036	d be	3 ☐ Widowed 4 🕱 Divorced  15. Decedent's Edu	Year or Dates: 19	82	ient's Usual Occupa			C	aucasian
15 in 72 in 72	Completed	(Specify only highest grad	de completed)	(Give	kind of work done of OO NOT use retired	durina most	of working	16b. Kind of Busine	ss/industry
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Maryland 2121 (at 2 should be filed within the and Mental Hygiene. 27 is marked other then "treumatic event, the Ment	Be C	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Middle		
Vlai Ments Ments arked	To E	Robert Ed	lward Willey				Thelma G	Geraldine	Corkran
Aar 2 sh 2 sh 1s m		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailin	g Address (Street a	and Number	or Rural Route Numb	ber, City or Town, State	a, Zip Code)
5 8 8 5		Thelma Willey 20a. Method of Disposition	Mother 20h P		Market sition (Name of	Stree	et, Dento	on, Maryl	and 21629
0 00		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State $\operatorname{\mathtt{M}} olimits^c$	ryTan	d Easte	rn   5	5/13/05		
Baltimo permit. Pag Department Importent: I any injury o		' 4 ☐ Donation 5 ☐ Other (Specify) 21 Ignature of Juneral Service License	Sh	ore V	et.Ceme	tery		Beulah,	
Depa Depa Impo		1 tauxoful	Please					A. Denton, M	21629 aryland
Jan. J.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death ne cause on each line.	n. Do not ente	er the mode of dyin	g, such as c	ardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a Cocaine Into	cicatio	n				Onset and Death
/Medical Examiner		Toolsing in doubly	Due to (or as a consequence	uence of):					
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uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
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68760, ificate be ex g physician as the buria	edical		d.					-	
Box 61 eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of o	delivery
death death death d for	Physiclan/M	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	hys	9 Unknown	9□ Unknown						
S, L	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	nderlying cause give	en in Part I.		_	to the cause of death?  Probably 4 Nunknown
cord w require been sig	Completed						24a. Was	s an 24b Were	autopsy findings available
I Re( The lavate has	dwo						auto	ppsy prior t ormed? death	o completion of cause of ?
	O O	25. Was case referred to medical				26. Place	1 XYes of Death (Check only		es 2 No
of Vita Physicien: this certific	To B	examiner? 1 🔀 Yes 2 🗆 No	Hospital: 1 ☐ Inpatient 2X	ER/Outpatien	t 3 DOA Othe			idence 6 □Other (Si	оесіfy)
		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury Forman, Day Year)	8b. Time of <b>OUNG</b> Y	28c. Injury Work	at	28d. Describe	how injury occurred	unk
Vision Attending r death. ector: After by the fune	catle	2 ☐ Accident investigation	5-7-05	9:20	<b>A</b> M 1□	Yes <b>X</b> □N			
Division  or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 6 <b>A</b> Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location ( City or To	(Street and Number or wn, State) <b>900 M</b> a	Rucal Route Number, Irket Street
Di lospitel or thours afte unerel Dir sly filled in	Ce	202 Contition 1 Continue Phys	Scene	uladaa daash	and the size		Denton		
Divisi To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examinal and manner stated.	wieuge, death	estigation, in my op	ie, date and pinion, death	place, and due to the noccurred at the time,	date and place, and d	as stated. ue to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (Mo	nth, Day, Year)
		) (luct 2	,		OCI	ME		May 9, 200.	5
		30. Name and address of person who co	4 4 0	23a) (Type,	,	C			
		141011	310, MD	turo	III Penn	Stree	et Baltimo	ore, Maryla	and 21201
St Regist	ate	31. Date filed (Month, MAYAY) 8	2005 32. Redistrar's Signa	ture	hard a				
ricgis	. 21		- Comment	15	TO SE				

			For	State of Marylan	d / Departme	ent of He	alth and M	lental Hygie	ne o o o o	
			1 - State Registrar		Certifica	ate of D	eath	Reg.	No. 4UUD	1686
			1. Decedent's Name (First, Middle, La	ist)				2. Date of Death	Day Year	3. Time of Death
	Physic /Medi		Edward	Emanue	/ Wat	Kins	5	April 2	9 2005	0322
	Exami		4a Facility Name (If not institution, gir	ve street and number)	4b. C		ocation of Death		4c. County of Death	
			Porchester GENE	ral Hospita	1 Ca	mbria	19e		Dorches	ster
	Funeral Director			7. Age (In yrs. 102M 2 F		der 1 Year   I	Hours Min.	8. Date of Birth (Month, Day, Ye Sept, 141	9. Birth	nplace (State or Foreigntry)
	77		Usual Residence of Decedent					2011171	///////	ryland
	h the Maryland r 28a-f show cnotified at		10a. State 10b. County	10c. City	, Town or Location	1				10d. Inside City Limit
5	Mar F-1 s	į	MD Dorc	hester	Cambr	ridge	2			1 DYes 2 □ N
2	or 28s	re	10e. Street and Number			Zip Code		10g.	Citizen of What Cou	untry?
3	ges 1 and 2 should be filed within 72 hours after death with to f Health and Mental Hygiene. If itam 27 is marked other than "neturel; or itams 23a or or other freumatic event, the Medical Examiner must be reconstructed by	Funeral Director	800- Hig	h Street		2161	3		USA	
0	er de	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was De	cedent of Hisp pecify Cuban,	anic Origin? (Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian, o, etc.
36	72 hours after neturel', or Ita	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No/94	. IIIYes	2 No .	Specify:		Specify:	
5-0036	72 hours "neturel", adical Ex	pe pe	15. Decedent's E	Year or Dates: 194	16a. Decedent's U	aval Ossvestia		400		cK
	n 72 "ne	Be Completed	(Specify only highest gr	ade completed)	(Give kind of life DO NO)	work done dur. Vise retired	ing most of work	ing 160	. Kind of Business/li	ndustry
2121	within lene. than "	Ę,	Elementary/Secondary (0-12)	College (1-4or 5+)	Socia			C.	tate of	Marchan
	filed within I Hygiene. other then	ပို	17. Father's Name (First, Middle, Last	)	Jocha		ov Kev 8. Mother's Name	e (First, Middle, Maid		viar gravi
Maryland	ld be ental ked c	o B	Emanuel	F Mant	Kins		1/2 . (	1 0	- 0	2
7	2 should be and Menta Is marked sumatic ev	2	19a. Informant's Name/Relationship			ass (Street and	7Urrit	al Route Number, Cit	T CaM	in Code
Z	d 2 s th ar treu treu		Eding Mi	itkins	Pag L	101-6		1 1 1	ΑΛ.	f 1 1 1 1
é,	is 1 and of Health itam 27 othar tr		20a. Method of Disposition		lace of Disposition (/	Vaine of		ambrid		own, State
2	ages nt of t: If if		1 ☑ Burial 2 ☐ Cremation 3 ☐	Hemoval from State	emetery, crematory c	· . '	-1		anexa e.	
Baltimore,	permit. Pag Department Importent: any injury o		<ul><li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li></ul>		teran's C	emeter	14 3 / 1	4/05/1	urlock	Maryland
Ba	permit. Departr Importe any inju		and the service city	c 21	2 Hen	RY Fu	werea!	Home, P. A.		10 01/1
			23° Part 1 From the disease or con	onlinations that caused the death	Do not optor the m	Vashi	ngton	St. Cambi	ridge/	Approximate
			23a. Part1 Enter the disease, or conshock or heart failure. List only	6)		. /	/ source cardiac c	or respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Kespi		for	leve			
	Examiner			Due to (or as a consequ	uence of):					
		-	Sequentially list conditions,	b. Due to lo as a consequ	ees 100					
	ed	-lue	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to to as a consequ	ience or):	1/h	me			
	and I-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ						
60,	be ey ician buria	표		Chair &	1/4/0	SAL	'al	Lucy o	diseare	
68760,	ificate be executed physician and as the burial-transit	edical		d Carrove	, ,					
			IF FEMALE:	23c. If yes, outcome of pregnal	nev				201.01.01.0	
Вох	death cert e attending id for use a	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic				23d. Date of deliv Month	rery Day Year
o.	0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	3 0 0 0	(Specify)				
۵.	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying	a cause given i	in Part I.	23e. Did tobaco	o use contribute to t	the cause of death?
Records,	sign sign d be	d by				3				bably 4 □Unknowr
Ö	w requir been si should	ete						-		
Sec.	The law ate has I page 2 s	Completed						24a. Was an autopsy	prior to co	opsy findings available empletion of cause of
F	Th ate	Col						performed		2□ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11 and 12			6. Place of Death	Check onle one		
of \	nding Physician: th. : After this certifica ! tuneral director, p	P	1 ☐ Yes 2 No		ER/Outpatient 3			me 5 Residence		fy)
	ing F	- U	27. Manner of Death 1 ☐ Hatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe how in	jury occurred	
Sio	tendi Jeath. Tor: A the fu	catl	2 ☐ Accident investigatio		М	1 🗆 Yes	3 2 □ No			
Division	ital or Attending its after death. ral Director: Afte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fact )	ory, office		28f. Location (Street City or Town, St		al Route Number,
	ital o	Ce								

To tha Hospit within 24 hour To the Funers completely filk

Watkins, Edward

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Multanman AP 2AL 305 Aurora ST

Registrar

		4	FOR AMERICATIS	d / Department of Health and M Certificate of Death		2000 1000
-		_	State Registrar 6.7.18. PerFH PC 5-4-05cr  1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death Month Da	3. Time of Death
	Physicia /Medic	al	mamie J. Warren	the City Town and applies of Death	5 - 2	
	Examin Funeral Director	G!	4a. Facility Name (If not institution, give street and number)  Mariner Health of SS  5. Social Security Number  6. Sex  7. Age (In yrs. le	4b. City, Town, or Location of Death  About Silver Spring  Start British Spring  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year	Entopmery County
	D	-	Usual Residence of Decedent  10a. State 10b. County 10c. City	, Town or Location		10d. Inside City Limits
	he Maryla 28e-f shov	ector	md. montgomery Sill	ver Spring, md.	10a. C	1 Yes 2 □ No
(0	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28e-f show the Medical Examinatr mat be notified at	Funeral Director	901-Arcola Avenue S  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  11. Never Married 20 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	S. Md. 20902	2	14. Race - American Indian, Black, White, etc.
-003	tural', o	ed by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	16a Decedent's Usual Occupation	16b.	Specify Black Kind of Business/Industry
21215-0036	d within 72 giene. er than "naic, the Medic.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of worki life. DO NOT use retired)  COOK	Col	lege PK. Society HM
	d be filed antal Hygi ted other c event, I	Be	17. Father's Name (First, Middle, Last)  DOC OGMOIND	18. Mother's Name	(First, Middle, Maide	n Sumame) Richardson
Maryland	2 should and Me Is mark aumati	ဥ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura		
	s 1 and 2 should t Health and Men Item 27 Is marke other traumatic		ZUA. Method of Disposition		ion Rd, Sul Date 20c. 1	Location - City or Town, State
Baltimore,	Page ent o nt: If ry or		1 A Donation 5 Other (Specify)	in Bast Church 5-6	-05 We	eleone, Md.
Ball	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee  Latterne to montainey 2'	22. Name and Address of Facility  19 Tyron & J. Young	7. H. 719	Wash, D.C. 20011 -Kenney St. M.W.
	Physician		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Finat disease or condition	n. Do not enfer the mode of dying, such as cárdiac o	or respiratory arrest,	Approximate Intervat Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence)			
0,	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence consequence)  c.  Due to (or as a consequence)			
68760	icate be physici s the bu	dical	d			
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	I death 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
Φ.	uires that t signed by ild be deta	þ	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.		o use contribute to the cause of death?  2 10 3 1 Probably 4 Unknown
Records,	The law require sate has been sig page 2 should t	Completed	GANGRENE OF FEE	719	24a. Was an autopsy performed?	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Other	h Check on one	a Cohas (Sassiful
of	ding Phys h. After this funeral di	on; To	1 Yes 2 No. 1 Inpatient 2 2  27. Manner Yeath 1 atural 5 Pending (Month, Day Year)	28b. Time of linjury at Work?	ome 5 Residence 28d. Describe how in	
Division	al or Attending after death. Director: After d in by the fune	Certification;	2 Accident investigation		28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my kno 2 Medicel Exeminer: On the basis of examina and manner stated.	wledge, death occurred at the time, date and place, tion and/or investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
)	To the within 2 To the comple	Med	29b. Signature and title of pertifier	29c, License number 0 9834		Date signed (Month, Day, Year)
R	$\sqrt{3}$		30. Name and address of person who completed cause of death (Item FARRY ROSEMISAVIA F 720	n 23a) (Type, Print)  FARRAGUT AVE. K	EUS NO	TON, MR 20895
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 0 4 2005	Apole		

			1 - For State Registrar	State of Ma	aryland /		artment ortificate			nd Me	_	giene	2005	16865
П	Physici	an	1. Decedent's Name (First, Middle,	Last)						2	2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		CURTIS		WAR	REN	, JR.				MAY 1	, 20	05	7:18 p <sup>M</sup>
1	Examin	er	4a. Facility Name (If not institution, §	i i			4b. City, To						County of Deat	
_	-		3701 STONESBOE  5. Social Security Number 6		(In yrs. last t	oirthday)	FT.		H I N G If Under 2		3. Date of Bir			GEORGES
ŀ	Funeral Director		578-72-3802	10 <b>X</b> M 2□F	5.3	Yrs.			Hours	Min.	(Month, Da	y, Year)	1 S.0	hplace (State or Foreign untry)
	D	Ì	Usual Residence of Decedent								10-10	-195	1 10.1	
	arylar show	_	10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits
	he M	ectc	MD P.G.		FT.	WAS	HINGT					40. 07.	(117 . 0	1X Yes 2 No
	a or 2	Funeral Director					10f. Zip Co		,				en of What Co	untry?
	ns 23	eral	3701 STONESE	12. Was Decedent 8	Ever in U.S.	13. \		0 7 4 4	-	in? (Speci	ifv Yes or No		S.A.	rican Indian.
(0	ritter d ritter	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces?			Was Decedent f Yes, specify			Puerto Ri	ican, etc.)		Black, White	
93	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jical Exactriat must be collided at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☐	XNo .	Specity:			5	Specify: BI	LACK
21215-0036	72 ho	Completed	15. Decedent's (Specify only highest		16	a. Deced (Give	dent's Usual ( kind of work of DO NOT use	occupatione dur	on ring most	of working	7	16b. Kind	d of Business/	Industry
121	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	DO NOT use : PAIN'					GTA	NT FOO	DD INC.
	Hygie Hygie thar i	ပိ	1 2 17. Father's Name (First, Middle, La	st)					B. Mother	's Name /	First, Middle,			22.0.
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatth and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Exercites must be notified at once.	To Be	CURTIS	- •	WARR	ΕN	SR		oro		М.		ERRIN	
ary	shound Mind Mind Mind Mind	-	19a. Informant's Name/Relationship	(Type, Print)										Tip Code) 20744
	alth a		MARION C. WARR	EN - WIFE									HINGTO	_ +
Baltimore,	es 1 a of He of He fitam r oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3	Damoual from State	20b. Place cemet	of Dispo	sition (Name natory or othe	of r place)	ļ	Da	te	20c. Loca	ation - City or	Town, State
Ĕ	Page ment ant: I		'4 □Donation 5 □ Other (Spe			RREC	CTION	CEM	0 1	5-06	-05	CLIN	NTON,	MARYLAND
alt	Depertit Depertit Import any Inj		21. Signature of Funeral Service Lie	enstee		22	. Name and	Address	of Facility	TAYI	OR'S	FUNI	ERAL F	IOME
	<u>00589</u>		P/J.C. 6	Daylor									W WASH	I.DC 20001
l,			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused ly one cases on each lin	the death. Do						respiratory a	rest,		Approximate Interval Between Onset and Death
	Pnysician ' /Medical		Immediate Cause (Final disease or condition resulting in death)	_a Metas	tatic	Cole	on Co	erci	nome	•				
	Examiner		,	Due to (or as a	a consequence	a of):								
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequenc	e of):								
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	an an rial-tr		resulting in death) Last	Due to (or as a	a consequence	e of):								
8760,	ate be executed obysician and the burial-transit	Icai		d										
9	entific ling p	Mec	IF FEMALE:											
Box	death certifica e attending ph of for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal dea		Ectopic pregi					23	ld. Date of deli Month	very Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 [	Other (speci	ry)						
P.0	= 00	y Ph	Part II. Dther significant conditions	contributing to death bu	it not resulting	in the ur	nderlying caus	e given i	in Part I.		23e. Did to	bacco use	e contribute to	the cause of death?
ds	requires een sign	d by									101	es 2 🗆	No 3 ☐ Pro	bably 4 Unknown
Vital Records,	law requir as been s 2 should	Completed									24a. Was	an	24b. Were au	topsy findings available
Re	The lav	ошь									autop	med?	prior to death?	ompletion of cause of
ital	ysician: The is certificate hadirector, page	0	25. Was case referred to medical					2	6. Place	of Death (	1 □ Yes Check only o		1 103	21110
	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier	nt 2 ERV	utpatien	t 3 DOA	Othor					□Other (Spec	ufy)
n of	ng Ph		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b	. Time of Injury	28c.	Injury at Work?	t	28	d. Describe I	now injury	occurred	
Sio	Attending r death. ector: After by the funer	catio	2 Accident investigat 3 Suicide 6 Could not	ho			М		s 2 🗆 N					
Division	or Ati	Certification:	4 Homicide determine		ry - At home, :. (Specify)	farm, stre	eet, factory, o	ffice		28	f. Location (S City or Tox		Number or Ru	ral Route Number,
	Hospital		29a. Certifier 1饭 Certifying	Physician: To the best of	of my knowled	TO dooth		h a Airea	4-10-004	alass an	d due to the			
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		Physician: To the best of eminer: On the basis of and manner sta	examination a	ind/or inv	estigation, in	my opini	ion, death	occurred	at the time,	date and p	lace, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. L	icense n	umber			29d. Date	signed (Month	, Day, Year)
			Dan	200	Sim >		D	0.5	990	42		Man	3 2	005
10	11		30. Name and address of person wh	o completed cause of de	eath (Item 23a	) (Type,	Print)		5 / (		-45	1		
1	- (//		DR. Deepnary		rri	892	6 wou	days	200	Roa	d 20	1 Cl	inton !	40 20735
	Sta		31. Date filed (Month, Day, Year) / MAY 0 4 200	2. Registra	r's Signature	1		J					signed (Month	
	Registr	ar	MAY 0 4 200	please	A A	784								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

50	1	State of Maryland / Department / Department / Depart			
Physicia	n	1. Decedent's Name (First, Middle, Last)  Da'Vontai Tupac Williams		2. Date of Death May 6, 2	8ax 5 Year 3. Time of Death 1220 P M
/Medica Examine		4a. Facility Name (If not institution, give street and number) Malcolm Grow Hospital	4b. City, Town, or Location of Death Andrews Air Force	Base	4c. County of Death Prince George's
Funeral Director		5. Social Security Number  220-71-1483  6. Sex 1X M 2□ F  7. Age (In yrs. last birthday) Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.   2   2   1	8. Date of Birth (Month, Day, Ye	ear) 9. Birthplace (State or Foreign Country) 2005 Washington, DC
show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo  Maryland Prince George District			10d. Inside City Limits 15€ Yes 2 □ No
with tha M a or 28a-f be notifie	Director	10e. Street and Number	10f. Zip Code		Citizen of What Country?
or itams 236	Funeral	1 t⊽ Never Married 2 ☐ Married 1 ☐ Yes 2 tv No	20747  Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.  Specify: Black
	Completed by	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Dece (Give only highest grade completed) (Give	ident's Usual Occupation kind of work done during most of work DO NOT use retired)	sing 16t	p. Kind of Business/Industry
ild ba filed wi lental Hygien kad othar th lic event, ILE	o Be Con	0 17. Father's Name (First, Middle, Last) Darryl Robinson		e (First, Middle, Mai	den Sumame)
nd 2 shou lith and M 27 Is mar r traumat	_		ing Address <i>(Street and Number or Ru</i> District Heights		ity or Town, State, Zip Code) 20747 trict Heights, MD
Pages 1 all ent of Hea nt: If Item ry or otha		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  20b. Place of Disposition cemetery, cre Resurrect	osition (Name of matory or other place) tion Cemetery 5/1		c. Location - City or Town, State Linton, Maryland
permit. I Departm Importal any inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility lexander S. Pope 538 Marlboro Pike	Funeral Ho	omes ille, MD 20747
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)		or respiratory arrest	Approximate Interval Between Onset and Death
icate be executed physician and s the burial-transit	ca	that initiated events resulting in death) Last    C. Due to (or as a consequence of):			
the death certificate y the attending phy: ched for use as the	Physiclan/Medl		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
uires that the der	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Aunknown
rsiclan: The law requir s certificate has been si lirector, page 2 should I	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funaral Diractor: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	To Be	25. Was case referred to medical examiner?  1 \( \times \) Yes 2 \( \times \) No  27. Manner of Death  1 \( \times \) Natural  5 \( \times \) Pending (Mooth, Day Year)  2 \( \times \) Accident  28a. Date of Injury (Mooth, Day Year)  1 \( \times \) Natural  2 \( \times \) Accident	of 28c. Injury at Work?	ath Check onl one lome 5 Residence 28d. Describe how	ce 6 □Other ( <i>Specify</i> ) injury occurred <b>unk</b>
ital or Atters after detail Diractored ed in by the	Certification:	3 Suicide 6 A Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)  Found at residence	9	leights P	<u> </u>
the Hospi in 24 hour the Funar pletely fill	edical	29a. Certifier (Check anly one)  Certifying Physicien: To the best of my knowledge, deal of the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	e, and due to the cau arred at the time, date	e and place, and due to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	OCME		Lay 7, 2005
		30. Name and address of person who completed cause of death (Item 23a) (Type LING LI, M.D.	111 Penn Street	Baltimore	, Maryland 21201
Sta Registi		31. Date filed (Month, Day, Year)  MAY 1 2 2005	de)		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12, Month **Physician** 2005 1:34 Ρм Ellen C. Allen May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1603 Treber Court Baltimore Lutherville 8. Date of Birth (Month, Day, Year) AUG 5, 1 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 155-03-5272 10 M 20 F 85 Director 191 New Jersey Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Lutherville Maryland Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21093 Items 23a 1603 Treber Court USA Funerai Pages 1 and 2 should be filed within 72 hours after deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: White Specify. þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ellen Basini Edward Lausmohr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health a Importent: if Item 27 is any injury or other treu-Judith Hanford/daughter 1603 Treber Court Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 5/17/05 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a rdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final tailure espiva **Physician** disease or condition resulting in death) /Medical consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Division of Vital Records, P.O. Box 68760, signed by the attending physicien d be detached for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 22 No has 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ٩ this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the F 29d. Date signed (Month, Day, Year) 29b. Signature a 21204 ress of person who completed cause

Registrar

DHMH 17 Rev 1/2001

State

2. Registrar's Signature

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MAY 1 9 2005

31. Date filed (Month, Day, Year)

			For Stete Registrar	Stat	e of Mar	yland / De <i>C</i>	partmer ertificat	it of H	ealth a Death	ınd M		jiene () (	15	168	58
	q		Decedent's Name (First, Middle	, Last)				_			2. Date of Dea		Year	3. Time of	Death
	Physici /Medic		William	Pau1		Alark					Month May	12 2	2005	1:18	a <sup>M</sup>
	Examin		4a. Facility Name (If not institution	, give street an	d number)		4b. City,	Town, or	Location o	f Death		4c. Count	y of Death		
		п	Anne Arundel	Medical	Cente	r		nnapo				Anne	Arui	ndel	
	Funeral		5. Social Security Number	6. Sex		In yrs. last birthd	Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	: Year)	9. Birth Cou	place (State or intry)	Foreign
	Director		213-44-8903	IEN IVI Z	6	0 Yrs					July 10	,1944	Mary	yland	
	and *		Usual Residence of Decedent  10a. State 10b. County		1	Oc. City, Town or	Location						1	10d. Inside Cit	y Limits
	Aaryli F sho	5		A 1 1		Ammama'	1 4 0							1 🗌 Yes	2 💢 No
	the 1	Director	MD Anne  10e. Street and Number	Arundel		Annapo.		Code			1	l0g. Citizen of	What Cou	intry?	
	With 3e or	<u> </u>	10 E Greystone	Court				214	103			USA			
	me 2;	Funeral	11. Marital Status	12. Was	Decedent Ev	er in U.S. 1	3. Was Dece			gin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ce - Amer	ican Indian,	
5	r Iter	F	1 Never Married 2 Married	ied 1 □	ed Forces? Yes_2 ∑ No					i, Puerto	Rican, etc.)		ack, White	, etc. lack	
3	el', o	þ	3 Widowed 4 Divorced	If Year	s, Give or Dates:		1 🗌 Yes	2 <b>A</b> J No	Specify:			Spec	fy: D	Tack	
ה ה	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel; or Iteme 23e or 28e-f show ant, the Modical Exacinetroust be notified at	Completed	15. Deceden (Specify only highe	t's Education	ated)	16a. De	cedent's Usu ive kind of wo a. DO NOT u	al Occupa	ation during most	t of worki	ing	16b. Kind of I	Business/Ir	ndustry	
7	ifthin if if if if if if if if if if if if if	npl	Elementary/Secondary (0-12)		ege (1-4or 5+)				-						
7	illed withir Hygiene. other then	ပိ	47 Cata de Nama (Cine Adiddia	1	4	Se	ction	Chief		r'o Nome	e (First, Middle,			irity A	dmin.
=	be fi	Be	17. Father's Name (First, Middle,	Lasi)								waluen Suma	mej		
7	2 should be and Mental Is marked o	은	Unknown	his Office Origin	41	40h 84	-: Add	· /Ctroot ·			Ordway	City or Tour	Ctoto 7	'n Cadal	
2	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other then other traumatic event, Ire M		19a. Informant's Name/Relations				1	-			al Route Number				
ນົ	1 and 4ealtl 9m 2		Olga D. Felici	Lano-Ala	irk (Wi	20b. Place of Di	sposition (Na	me of			Annapo]	LLS , I'LL 20c. Location			
2	tges if it		1 ☐ Burial 2XX remation		from State	cemetery,	rematory or	other plac		- /16	10				
Dallillo	t. Partmer		' 4 ☐ Donation 5 ☐ Other (S			Metro	22. Name a				/2005	Baltim	ore,	MID	
Ö	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra <u>once.</u>		7	me			Har	desty	Fune	eral	Home, H	P.A.	MIX 21	401	
			23a. Part1. Enter the disease, or	complications	that caused th	ne death. Do not		a morning			e , Annap		MD 2.	Approximate	
			shock, or heart failure. List Immediate Cause (Final	only one cause	on each line									Interval Betw Onset and D	eath
	Physician /Medical		disease or condition resulting in death)	a	UN	19 Can	OV							15 m	1/V _
	Examiner				Je to (or as a	consequence of):									
		اة	Sequentially list conditions, it any, leaung to immediate cause. Enter Underlying Cause (Disease or injury	b. — Ex	ia to (or as a	oonsequence of):							12		
	rted Insit	min	cause. Enter Underlying Cause (Disease or injury	<b>S</b>											
	exect n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Du	e to (or as a	consequence of):									
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0	tificat g phy as th														
Š	w requires that the death certifics been signed by the attending pr should be detached for use as It	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		s, outcome of	pregnancy Fetal death	3 □Ectopic p	regnancy					ate of deliv		
0	death e atten ed for u	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🗆	Pregnant at tii Unknown		5 Other (s						lonth	Day Y	ear
5	law requires that the as been signed by the 2 should be detache	hys	9 Unknown	90	Unknown								1174		-
ń	as tha	by F	Part II. Other significant conditi	ons contributing	g to death but	not resulting in th	e underlying	cause give	en in Part I.	•				the cause of de	
cords,	aquire an sign										1/21 Y	es 2 🗆 No	3 ☐ Pro	bably 4 🗆 U	nknown
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Ĕ	The I	E O									perfor		death?	20 No	
Ø		O	25. Was case referred to medica	ıl					26. Place	of Deat	h (Check only or				
>	> 20 0	To B	examiner? 1 Tes 2 No	Hospital:	1 Inpatient	2 ER/Outpa	tient 3 D	OA Oth	er: 4 🗆 Nu	ırsing Ho	me 5 Resid	ence 6 🗆 O	ther (Spec	ify)	
0	ding Ph h. After th funeral		27. Manoer of Death 1 ☑ Natural 5 ☐ Pendi	28a.	Date of Injury (Month, Day	Year) 28b. Tim	e of	28c. Injun Work	y at k?		28d. Describe h	ow injury occu	ırred		
Sion	Attending of death. Sector: After by the fune	atlo	2 Accident invest	igation			М		Yes 2	No					
<u>s</u>	r Atte	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289.	Place of Injury	y - At home, farm (Specify)	street, factor	ry, office			28f. Location (S City or Tow		ber or Rui	ral Route Numb	er,
2	rs after or el Dire	Cer	/												
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical	Examiner: On	the basis of e	my knowledge, d									
	To the hwithin 24	Medi	one)	and	l manner state			c. Licens				29d. Date sign			
	With Too	2	29b. Signature and title of certific	12	1		29	O C	O I I			Mais sign	17	) O O	
	Ti		100	IN	/			100	7196	)		1,101	160		
	10		30. Name and address of person	who completed	d cause of dea	ath (Item 23a) (Ty	pe, Print)	12)	#3	7	A	adis	MA	1621	
			31. Date filed (Month, Day, Year	10/24 (V	32 Registrar	's Signature	1991	. 1	11 /		11119	Porto	100	red	
•	Sta Regist	ate ' rar	MAY 1		A series in all	3 Orginature	Sale!					V			
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State of Maryland / Department of Health and Mental Hygiere 1- For Amend Item 1 per me G844 6-1-05 rtiffcate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 15, Year **Physician** 2005 4:45A. ALDRIDGE DAMON A. /Medical 4a. Facility Name (If not institution, give street and number)
100 Blk.Diener Place 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 10 M 20 F MARYLAND 214-02-794 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral', or items 23a or 28a-f show Examiner must be notified at 1 TYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 91A Completed by Funeral Pages 1 and 2 should be filed within 72 hours atter death vinent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Madical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paula KANDO/PH ALDRIDGE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's ame/Relationship (Type, item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State OUDON YORY 5 Other (Specify) Enforthmen ¹ 4 □ Donation 22. Name and Address of Facility Funeral Service Licensee 23a. Part Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gunshot Wounds Multiple Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) 68760 attending physician eq Physician/Medical certificate use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \[ \] No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 XResidence 6 □Other (Specify) SCENE 1 Inpatient 2 ER/Outpatient 3 DOA 1 X Yes 2 No P 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: Found AM 1 Natural 5 Pending investigation 15/05 1 ☐ Yes 2 🕱 No subject shot 2 Accident 81. Location (Greet and Number or Rural Route Number, City or Town, State) 100 BLK Diener Place Baltuwere MD 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide arking 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME MAY 15, 2005 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) Penn Street Baltimore, Maryland 21201 LANMO . Registrar's Signature 31. Date filed (Month, Day, Year) State

MAY 1 9 2005

	_1	State of Maryland / Department of Health and State AMEND ITEM #12 PER FH C844 6/02/05 III Registrar AMEND ITEM #1826 PER PHY C843 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	Mental F	lygiene Reg. No	2005	16870
Physician	1	Decedent's Name (First, Michile, Last)  WILLIAMM BERNARD BLACKWELL, JR.	2. Date of Month MAY	Da	Year 2005	3. Time of Death  10:40 P
/Medical Examiner		a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat			: County of Death	1,00101
		4005 BATEMAN AVENUE BALTIMORE CI		D	N/A	
Funeral Director		225-26-3538 X M 2 F 79 Yrs. Months Days Hours Min.	. (Month,	Day, Year, 17/1	)   Cou	place (State or Foreign ntry) RGINIA
show	-	Joan   Assidence of Decedent				10d. Inside City Limits
36  atter death with the Maryla or Items 23a or 28a 1 show intermed to the multiled at the mul	5	MD N/A BALTIMORE CITY				Yes 2 □ No
vith the Mar tor 288-1 st		0e. Street and Number 10f. Zip Code		10g. Ci	tizen of What Cou	ntry?
s 23a	5	4005 BATEMAN AVENUE 21216  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Yes or	No-	USA 14. Race - Ameri	can Indian
of the death varieties of the second	5	Armed Forces? US If Yes, specify Cuban, Mexican, Puer	nto Rican, etc.)		Black, White,	etc.
5-0036 72 hours after dea "naturel", or Items office Ex. culture	2	If Yes, Give ARMY 1 ☐ Yes XXNo Specify: NAVY			Specify: BL	ACK
d 21215-0036  tiled within 72 hours after death with the Maryland Hygiene.  ther then "naturel", or Items 23a or 28a-1 show ant, the Modeal Examinational Longith of the Completed by Funeral Director	בונו	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work done during most of work done during most of work do	orking		Cind of Business/Ir	*
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ind 2 be filed that Hyg and other event, le	ט 📗	17. Father's Name (First, Middle, Last)  18. Mother's Na	me (First, Mid			
		WILLIAM BERNARD BLACKWELL, SR. HELEN		KING		
Mar 12 shu h and 7 Is m traum		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailing Address ( <i>Street and Number or R</i>				01 - 1212 (2000) 20
_ = a - a	_	20a Method of Disposition 20b. Place of Disposition (Name of	E., Ba		MORE MI ocation - City or T	D_21216 own, State
A 8 0		**MBurial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  **Cemetery, crematory or other place)  MD. VETERANS CEM  GARRISON FOREST  5/	25/05	OM.	INGS MI	I.I.S MD
Baltimore, permit. Pages 1 a Department of He Importent: if item any injury or othe		21. Signature Pinsyral Service Licensee 22. Name and Address of Facility	OWELL	FUNI	ERAL HO	ME 21207
402.60	+	23a. Rate: There the disease, or complications that caused the death of not enter the mode of dying, such as cardia shock, or rear taptire. List only one cause on each line.	IGHTS ac or respirator	AVE y arrest,	, BALTI	Approximate
Pnysician		Immediate ause (Final				Interval Between Onset and Death
/Medical		diseased condition resulting in death)  a				JUN 13
Examiner		Sequentially list conditions.				
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76 Per le be	Z Z	d				
x 6876(		IF FEMALE:			1 - 12	
Box 68 death certifica e attending physical for use as the inclination of the inclination	Idily	23b. Was decedent pregnant in the past 12 months?			23d. Date of deliv Month	ery Day Year
. 0 00 0 -	1321	1   Yes 2   No 9   Unknown				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. D	id tobacco	use contribute to	the cause of death?
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Beccharge be a staw r	Completed		24a. V	/as an utopsy erformed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
Vital Resident The lar certificate has rector, page 2		Of Was an extended to modified	1□ Ye	s 2 DK		2 PN0
Share of Vita of Vita Physicien: this certifical director,	o De	25. Was case referred to medical examiner?  1   Yes   2   No   2   EN/Outpatient   3   DOA   Other: 4   Nursing	Home 5 XX		6 Mother (Speci	Hospies
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Division Division or Attending after death. Director: After	Certification;	3 ☐ Suicide 4 ☐ Homicide  Solution of the determined determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28t. Location City or	n (Street a Town, Stai	and Number or Rur te)	al Houte Number,
Division of Vital R.  Division of Vital R.  To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate in completely filled in by the funeral director, page	edical	29a. Certifier  (Check/only  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.				
thin 24 the F	Mea	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Da	ate signed (Month,	Day, Year)
To with To cor	-	111 X Styr 111 LW D44715	5	خ	5.17.0	5
-11	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		T	1- 11:	> 0
IM		FRANCIS X. STRAIN, III, MD 30 (ST)	Aul	DA	MI	21202
State Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature				
DHMH 17 Rev 1/200	Ģ	MAY 1 9 2005 Seem & Jack				

ORIGINAL

		-	4 -01.	Pepartment of Health and Modernificate of Death	lental Hygie	211115	16871
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death	. No. 9 0 0	3. Time of Death
	nysicia		LAURA VIRGINIA BAKER		MAY 15,	Day Year 2005	1:15 P <sup>M</sup>
	Medic xamine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1411 15,	4c. County of Death	
			7121 B&A BLVD	GLEN BURNIE		ANNE ARU	NDEL
	neral ector		5. Sociat Security Number  218.42.2667  Usual Residence of Decedent	hday) If Under 1 Year tf Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y MAY 21,	9. Birth Con	nplace (State or Foreign untry) <b>MD</b>
land	ם		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
Man.	palilled	tor	MD ANNE ARUNDEL GLEN B	URNTE			1 ☐ Yes 2 ☐ No
ith the	2	Directo	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	
ath w	T T T T T T T T T T T T T T T T T T T	rai	7121 B&A BLVD	21061		USA	
G 21215-UU35 filed within 72 hours after death with the Maryland Hygiene.		by Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Never Married 2 Married Armed Forces?  1 Yes XXNo ft Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spitt Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:	Rican, etc.)	14. Race - Amer Black, White Specify:	e, etc.
2-C	lical	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work)	ing 16	b. Kind of Business/I	
The state of	We	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	ng		
led y	- i		12 17. Father's Name (First, Middle, Last)	HOMEMAKER	(First, Middle, Ma	OWN HOM	E
2 2 E		To Be	LAWRENCE F. MURNAGHAN	MARY E	. NEUSING	GER	
= = "	other traumatic	3	GLORIA E. REUWER DAUGHTER 71	Mailing Address (Street and Number or Rura  21 B&A BLVD GLEN BUR	NIE, MD 2	21061	
Baltimore, permit. Pages 1 a Department of Hea	ury or ot	1	20a. Method of Disposition  1	Disposition (Name of commands) AWN CEMETERY		c. Location - City or TARRIOTTSVI	
Dermit.	any inj		21. Signatu et Funeral Service Lice See  K. CREGOKK FINK MO1148	FINK FUNERAL FROME, 426 CRAIN HWY SW GL		E. MD 2106	1
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or leart failure. List only one cause on each line.				Approximate tnterval Between
Physi			tmmediate Cause (Finat disease or condition	an sem			Onset and Death
/Med Exam		1	resulting in death)  Due to (or as a consequence of	f):			
		-	Sequentially list conditions, if any leading to immediate Due to for as a consequence	ntia			
betr	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury				
<b>60,</b> be executed	burial-transit	Еха	that initiated events c. resulting in death) Last C.  Due to (or as a consequence of	f):			
ite be ex	2 9	icai	d				
rtifica	as as a	Med	IF FEMALE:			<u></u>	
I HECORDS, P.O. BOX 687. The law requires that the death certificate	tached for use as I	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delik Month	very Day Year
s that	be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
guires	n d b				1 ☐ Yes	2 □ No 3 □ Pro	bably 4 DUnknown
	page 2 should	Completed			24a. Was an autopsy performe	d? death?	opsy findings available ompletion of cause of
Of VItal Physician: 1	rector,	Be	25. Was case referred to medical examiner?		Check on one		
hy shift	0 0	2	1 Tes 2 No 1 Inpatient 2 ER/Out		me Residence	e 6 Other (Spec	ify)
Affag Affag	funera	tion	Natural 5 Pending	me of 28c. Injury at york?  M 1 ☐ Yes 2 ☐ No	28d. Liescribe now	intury occurred	
DIVISION i or Attending after death. Director: Afte	In by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of tniury - At home, far building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
DIVISION To the Hospital or Attending within 24 hours after death.	letely fillec	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, for investigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To th within	comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month)	, Day, Year)
	5		30. Name and address of person who completed cause of death (ttem 23a) (	Type, Print)  Type / L.W / /	GB	mo	
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	) 1/		
R	egistra		30. Name and address of person who completed cause of death (Item 23a) (1 41 Z 31) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	parte			

CAURA D. BAKER

For pays amend item #1&20b PFR PHY & FR THE PROPERTY AMEND ITEM #1&20b PFR PHY & FR THE PROPERTY AMEND AND THE PRO 1. Decedent's Name (First, Middle, Last) A. BLUMENTHAL **Physician** heldon 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2387 BROAD RUN COURT FREDERICK JEFFERSON If Under 24 Hrs. 8. Date of Birth Hours Min. APR 2,1918 If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 87 Director 213-14-3387 Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 7 Is marked other then "neturel", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD FREDERICK **JEFFERSON** Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2387 BROAD RUN COURT 21755 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ☐Yes 2 X No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Heelih and Menial Hygiene. Importent: If item 27 is marked other then "ne any injury or other traumatic event, the Media 2006. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LINOTYPE OPERATOR NEWSPAPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BENJAMIN BLUMENTHAL  $\pm$ EVA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2387 BROAD RUN COURT - JEFFERSON, MD 21755 ARLENE B. KELLY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State BALTIMORE HEBREW CEM. 05/17/2005 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Ligenses 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal tailure **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or hijury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran ed by the attending physician and detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

s been signed by the Completed certificate has page 2 ral director. ledical Certification: To this After

þ

Be

23d. Date of delivery Month Dav

23e. Did tobacco use contribute to the cause of death?

3. Time of Death

10:10 A M

10d. Inside City Limits

USA

WHITE

FRIEDMAN

Approximate Interval Between Onset and Death

Years

Year

1 ☐ Yes 2 No

MD

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Artery

autopsy performed 1 Yes

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

25. Was case referred to medical

5 Pending

investigation

6 Could not be

1 Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

2203

29c. License number

29d. Date signed (Month, Day, Year) May 15,2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

State Registrar

land 31. Date filed (Month, Day, Year)



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death.

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filled in by

To the Hospitel or Attendi within 24 hours after death, To the Funerel Director; A

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Seachum largaret 130 AN 7000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Augsburg Lutheran Home Lochearn If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 216-05-4295 1□M 210 F 88 Yrs Director June 28. Maryland Usual Residence of Decedent Pegas 1 end 2 should be filed within 72 hours aftar death with the Maryland nent of Health end Mental Hygiene. 10a State 10b.County Baltimore 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Lochearn 1 ☐ Yes 2 ☒ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road 21207 by Funeral United States 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☒ No Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Sales Clerk/Cashier Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank E. Ditman E11a May Sme1tzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niece 6516 Lewis Road, Baldwin, MD 21013 Health Mary Rita Grant 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Woodlawn Cemetery 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) May 19, 2005 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133-4784 400 JJJ Fax1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, trock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Alzheiners Ristage Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the daath certificate be executed for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No Be Completed by ours efter death.

•••al Director: After this cartificate has been signe fillad in by the funeral director, pege 2 should be o 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 28 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 1 ☐ Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours en To the Funeral D completaly fillad in 29a. Certifier 1 📂 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 7005 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) Mais 25 37 15-61 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiepe 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Worley Baker, MAY 13, Clifton 2005 06:25 MM /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 11XM 2□ F Director 218-36-3026 65 Maryland Usual Residence of Decedent the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturet", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at Directo 1 ☐ Yes 2 XNo Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2622 Merrick Way 21009 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7, h and Mental Hygiene. 7 is marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) Paper Cutter Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vinton Oscar Baker Alice Cornelia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pern it. Pages 1 and 2 sh Dep. rtment of Health and Impr rtent: if item 27 is m any injury or other treum <u>once.</u> Marie Baker - Wife 2622 Merrick Way, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park 5/16/05 Parkville, Maryland 21. Signature of Funeral & rvice Liceusee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications of at 25 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CARDIDGENIC SHOCK /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 TYes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform To the Hospitei or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 1 Xnpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) No 0 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D3Ø263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) , M. D. 76.71 0 OSLER DRIVE TOWSON, MARYLAND 21204 State MAY 1 9 2005 Registrar

			1 - For State Registrar	State of	Maryland	_	artmen rtificat			and M	lental Hy	giene		168	375
	Physici	25	1. Decedent's Name (First, Middle,	Last)				_			2. Date of De	ath Da	/ Ye		of Death
1	/Medic		John	C.		Co	mrie				May	10	2005	11:4	5 p <sup>M</sup>
	Examir	er	4a. Fecility Name (If not institution,		•				Location o	of Death			County of D		
	E		Anne Arunde1  5. Social Security Number		enter '. Age (In yrs. I	ast birthday)	Ann If Under	apol	1S	24 Hrs.	8. Date of Bir		nne Ar		or Foreign
	Funeral Director		135-24-8317	<b>X</b> XM 2□ F	85	Yrs.	Months	Days	Hours	Min.	May 8,	iv. Year)	0 50	Birthplace (State Country) cotland	or r oreign
	D .		Usual Residence of Decedent												
	shov	5	MD Anne	Arundel	Toc. City	/, Town or Lo								10d. Inside	City Limits os 27/7/10
	28a-1	Director	10e. Street and Number	Arunder		Arno1	10f. Zip	Code				10a Cit	izen of What		AA
	3a or	0	1195 Forked Cr	ook Road			101. 2.10		012			rog. on	USA	Country	
	death	Funeral	11. Marital Status	12. Was Deced	tent Ever in U.	S. 13.	Was Dece			gin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race - A	mencan Indian,	
98	ours after death with the Marylan sat, or Items 23a or 28a-f show Examiner must be notified at		1 ☐ Never Married 2 ☐ Marrie		XXNo		1 ⊟ Yes		Specify:	i, Fuelto	nican, etc./		Specify:	/hite, etc. White	
Š		ed by	3 XWidowed 4 Divorced	Year or Dat	tes:							1 101 16			
15	in 72 n "nat	plete	15. Decedent' (Specify only highest	grade completed)		16a. Dece (Give life.	kind of wo DO NOT u	rk done d	lurina mos	t of worki	ing	16b, K	ind of Busine	ess/Industry	
212	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-4	4or 5+)	Supe	rviso	r				U	tilitv		
2	should be filed in Mental Hygie marked other metic event.	Be C	17. Father's Name (First, Middle, L	ast)			-		18. Mothe	r's Name	(First, Middle				
yla	should be ind Mental marked o	2	William Comrie								a Mitc				
Maryland 21215-0036	- m m =		19a. Informant's Name/Relationsh								il Route Numb				
	is 1 and 2 of Health item 27 I		Jacquelyn Sass 20a. Method of Disposition	i (Daught		lace of Dispo	o For	ked i	Creek		d, Arn			or Town, State	
JOL	0 0 = =		1 🔀 Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		late	lace of Dispo			1	/17/	2005				
Baltimore,	permit. Pag Department Important: I any injury o	1	21. Signalary of Funeral Service L		rai	irview	2. Name an	d Addres	s of Facilit	v	2005		tfield		
ä	Den Imp		17- A.C	Je-			Hard 12 R	esty idge	Fune 1v Av	ral enue	Home,	P.A.	s. MD	21401	
			23a. Part1. Enter the disease, or on shock, or heert failure. List of	omplications that can	used the death	. Do not ent	er the mod	e of dying	g, such as	cardiac c	or respiratory a	rrest,	,	Approxim Interval B	ate etween
-	Pnysician		Immediate Cause (Final disease or condition	6	·I	Ble	ed							Onset and	d Death
	/Medical Examiner		resulting in death)	Due to (o	r as a consequ	uence of):									
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consequ	neuce of).	wee							Year	2
$\overline{}$	uted d ansit	Examiner	Cause (Disease or injury												
o .	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (o	r as a consequ	uence of):						<u> </u>			
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dlcal		d											
9	entifica ling pl	Med	IF FEMALE:											-	
Вох	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		ome of pregna th 2 □ Fetal int at time of de	death 3[	Ectopic pr						23d. Date of Month	delivery Day	Year
0	by the	yslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov		Baul 3L	Other (sp	өспу)							
<u>α</u>	The law requires that the te has been signed by thoage 2 should be detache	by Pr	Part II. Other significant condition	s contributing to dea	ath but not resu	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did	obacco i	ise contribut	e to the cause of	f death?
rds	w requires been sig should b										1 🗆	Yes 2	□No 3□	Probably 4	Khown
Vital Records,	e law requ has been je 2 shoul	Completed				_					24a. Was		24b. Were	autopsy finding to completion of	s available
- B		E O					-					ormed? 2 <b>S</b> roo	death	1?	Cause of
/ita	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					Tier		of Death	(Check only	one)			
of \	S 5	2	1 Yes 2 No 27. Manner of Death	Hospital: 1	-	ER/Outpatier			4 LI NU		me 5□Resi			Specify)	
	ding h. After fune	tlon	Ratural 5 Pending	(Month	, Day Year)	28b. Time o Injury	M	8c. Injury! Work!	rat t? /es 2.⊟I		28d. Describe	now inju	y occurred		
Division	or Attending after death. Director: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of	of Injury - At ho	me, farm, str				1 2	28f. Location (	Street an	d Number o	Rural Route Nu	mber,
Ö		Cert	4  Homicide determin	building	g, etc. ( <i>Specif</i> y	1)				4	City or To	wn, State	)		
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the base	sis of examinal	wledge, deat tion and/or in	h occurred vestigation	at the tim , in my or	e, date an oinion, dea	d place, th occurr	and due to the ed at the time,	cause(s)	and manner t place, and	r as stated. due to the cause	(s)
	To th within To th comp	Me	29b. Signature and title of certifier				290	. License	number	0.7		29d. Da	e signed (M	onth, Day, Year)	
			MEN G				7	on	25 4	74		5/	11/2	005	
	1			no completed cause	of death (Item	23a) (Type,	Print)	21	1400	lien	/ ca	ten			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Sigha		60								
	Regist	rar	MMITOT	005	Will Const	-									

		1	For State		State	of Mai	ryland / Do	epartme C <i>ertifica</i>	ent of H ate of L	ealth : D <i>eath</i>	and Me		giene Reg. Ng.	05	16876
			Registrar  1. Decedent's Nam	ne (First, Middle	a, Last)						2	. Date of De		Vace	3. Time of Death
	Physicia	_			COVNL	5%					м	Month	16	2005	8:30p M
	/Medic	al -	a. Facility Name (					4b Ci	ty, Town, or	Location		ay		unty of Death	
	Examine	er '									0. 20				
			Joseph	Riche	y Hospi	ice :	Inc. (In yrs. last birth		ltimo der 1 Year	ore If Under	r 24 Hrs. R	. Date of Bir	th	9. Birth	nplace (State or Foreign
	Funeral		5. Social Security I		6. Sex <b>X</b> [X]M 2□ F			Month		Hours	Min.	(Month, Da	3y, Year) 38 2	Col	untry) MD
	Director		216-16				84 '					02	JO 2		TID
	pu »	-	Usual Residence of 10a. State	10b. County			10c. City, Town	or Location							10d. Inside City Limits
	sho	_		NA			Balti	nore							Yos 2 No
	8a-1	ct	MD		<u> </u>		Darcri		Zip Code				10g. Citizer	n of What Co	untry?
	or 2	i i	10e. Street and Nu					101.							,
	23a	- a	2826 We	st Mul	berry S	Stre	et		212	23	-1-1-2 (0-00	tu Van as N		U.S.A Race - Ame	
	dea	ne l	11. Marital Status		Armed	Forces?	ver in U.S.	If Yes, s	specify Cuba	an, Mexica	rigin? (Spec an, Puerto Ri	ican, etc.)		Black, White	
9	afte or it	by Funeral Director		rried 🔀 🕱 Mar	IT THS.	es 2 □ N Give	0	1 □ Ye	s 2XNo	Specify	<i>/</i> :		S	pecify: B1	lack
8	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or itams 23a or 28a-f show ant, it e Medical Exerting must be notified at	d b	3 Widowed	4 Divorced		or Dates:	1.40	Danadaatia 1	Inval Occur	ation			16h Kind	of Business/	
2-0	72 h natu	Completed	(Spe	15. Deceden acify only highe	nt's Education est grade complete	ed)	16a.	Decedent's U (Give kind of life. DO NO	work done	during mo	st of working	7	TOD. Tand	01 240111004	
21	ithin	npi	Elementary/Sec		_	e (1-4or 5-	+)	Dri		۵)			Cah	Comp	nanv
21	ed w /gier ier th	Col	llth g		na			DLI	ver	18 Moth	her's Name /	First Middle	, Maiden Su		
ng L	al H al H d oth	Be	17. Father's Name	a (First, Middle,	Lasti										
<u>a</u>	uld b Ment rrked stic s	2	Robert								de La		0.4	Ctata	Zin Codol
Maryland 21215-0036	nd 2 should be filed within the and Mental Hygiene. 27 Is marked other than "r traumetic avant, it e Mental Hygiene."				ship (Type, Print)									own, State, 2	
	Health tam 27 l		Betty	Cornis	sh-Daug	<u>hter</u>							C, Ba	TTCO!	Md 21223
re,	s 1 and if Healt itam 2 other		20a. Method of Di			Chana	20b. Place of cemeter	Disposition ( y, crematory	'Name of or other pla	се)	Ďa	ite	20c. Loca	tion - City or	10Wn, State
/2 E	Pages nent of H ent: If its ary or of		1 □ Burial 3	2 <b>X</b> Cremation 1 5 ☐ Other (\$	3 □Removal fr Specify)	om State	Metro	Crem	ator	y In	c. 5/	23/0	5 Bal	timo	re, Md
//6/05 Baltimore,	arth orten inju		21. Signature of I	Funeral Service	Licensee	1. (	)	22. Nam	e and Addre	ess of Fac	ility				
Ba /	permit. Pages 1 and Department of Healt Importent: If itam 2 any injury or other once.			10.00	etc 1	K. Y	mes	1200	h F/	aab	7	Balt	imore	bm .	_21215
5			2 a. Part1. Ente	r th disease, o	or complications that only one cause	nat caused	the death. Do r	ot enter the	mode of dyi	ng, such a	as cardiac or	respiratory	arrest,		Approximate Interval Between
			shock, or he Immediate Caus		t only one cause	on each lin	1STAT	11 7	7117	270	2 0	AN	COR		Onset and Death
	Physician /Medical		disease or condi resulting in death	tion	a	Let V	a consequence	··· (.	>LA I	) UC					1
	Examiner				Due	V O C	TATE	/ A_	1166	2R					UPAVS
		_	Sequentially list	conditions,	n		a consequence								
15	√ si si	Examiner	Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated ever	derlying or injury	<	•									
3,	and 1-trar	xan	that initiated ever resulting in death	nts n) Last	C. Due	e to (or as	a consequence	of):							
30 0	cate be executed physician and the burial-transit														
00 18	ate l	dicai			d										
6	certific nding pl use as I	Me	IF FEMALE:		23c If yes	outcome	of pregnancy						23	d. Date of de	alivery
Вох	that the death certific ed by the attending p detached for use as	by Physician/Me	23b. Was deced	lent pregnant 12 months?	1 □ i.	ive birth	2 Fetal death	3 ☐Ectop	oic pregnant r (specify)	СУ				Month	Day Year
~~~	e de	sic	1 ☐ Yes 9 ☐ Unknor			Jnknown	(IIIIo or douti)	0 🗆 0 (110	, Jopes y						
CV 9	requires that the een signed by th hould be detache	Phy			tions contributing	to death h	ut not resulting i	the underly	ina cause a	iven in Pai	rt I.	23e. Dio	d tobacco us	e contribute t	to the cause of death?
s s	es th igner	by	Part II. Other sig	minicant condi	nons contributing	10 000111 0	at 1101 1 a a a a a a a a a a a a a a a a					1 [	Yes 2	No 3□P	robably 4 Dunknown
C P	w requires that been signed to should be deta	Completed												0.45 144	
Too	> 00	ple											as an topsy rformed?	prior to death?	utopsy findings available completion of cause of
O E	The law rate has b page 2 sl	E	i									1 ☐ Yes		1 ☐ Ye	s 211 No
		Q)	25. Was case re	eferred to medic	cal					4-90-0	ace of Death			-5	
	Attending Physician: r death. sctor: After this certifica	To B	examiner?	2 PNo	Hospital:	1 🗆 Inpatie	ent 2 ER/O	utpatient 3[	J DOM						ecity) Hospice
7 / 5	ding Phys		27. Manner of D			Date of Inju (Month, Da		Time of Injury	28c. Inj W	ury at ork?	2	28d. Describ	e how injury	occurred	
Jest t	nding th.	atio	1 ☑ Natural 2 ☐ Acciden	14	stigation			N	1 [	Yes 2					
Sis	or Attendi after death. Diractor: A in by the fu	ific	3 ☐ Suicide 4 ☐ Homicio		d not be rmined 28e. I	Place of In	jury - At home, fa tc. <i>(Specify)</i>	arm, street, fa	actory, office	9		28f. Location City or	n (Street and Town, State)	Number or F	Rural Route Number,
36	in Diffe	Certification:	- I Hombie												
ober	Hospital 24 hours a Funarat (	alc	29a. Certifier	1 Certify	ying Physicien: T el Exeminer: On	To the best	of my knowledg	e, death occu	urred at the	time, date	and place, a	and due to the	ne cause(s) a	and manner a place, and du	as stated. ue to the cause(s)
K	To the Hos within 24 ho To the Fun completely	edical	(Check only one)	∠	and	manner si	ated.								
	To tha within 2 To the complet	M	29b. Signature	and title of certi	fier (	-			29c. Lice	nse numb	er				nth, Day, Year)
	L > F U		( )	X	Stu	h	1, M	1)	D	44	715	-	5	(7.0	5
	. 3 4	X	30. Name and a	address of person	on who completed	cause of	death (Item 23a)	(Type, Print	)	Λ	0	-P.		1 ,	_
	DX	1	FRAN	icis X	. STRA	ini	II, Mi	> 30	( ST	- VA	tul	0%	U /	W)	21202
.1	S	tate	31. Date filed (/				rar's Signature	-							
1	Regis			MAY 1	9 2005	ASTR	was &	Apa	(E)						

	Ple	ase Type or Prin end Item I State of Ma	t in Black Ind per phys ryland / Denai	elible Ink Ensur 8844 6-18-0 tment of Health ar	<b>All Copies Ar</b> To VI ad Mental Hygier	e Legible. ne	
	1 - State Registrar		Cert	ificate of Death	Reg. I	2005 16	877
Physician /Medical	+ MIVC	<b>2</b> δ (	-OCTAI	$\Theta$	65 1	Z ZOOS 6	ne of Death
Examiner	4a. Facility Name (If not institut	11	BAHMOO	4b. City, Town, or Location of I	Death	4c. County of Death	7
Funeral Director	5. Social Security Number 319-13-8846	6. Set 7. Age	(In yrs. last birthday)	If Under 1 Year If Under 24			ate or Foreign
ryland	Usual Residence of Decedent  10a. State  10b. Cour	ty	10c. City, Town or Loca	ation			de City Limits
5 fiter death with the Ma refers 23e or 28e+1 s uner must be notified Funeral Directoi	10e. Street and Number		130	10f. Zip Code	10g.	Citizen of What Country?	¥es 2□No
ath with	400 Millin	ston Ave		2122	3	USA	
ν. ε ε ο ο ο ο ο ο ο ο ο ο ο ο ο ο ο ο ο	3 de Widowed 4 □ Divorc	If Vac Give	0	as Decedent of Hispanic Origin Yes, specify Cuban, Mexican, I Yes 2 No Specify:	l? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American India Black, White, etc.  Specify:	un,
15-0036 72 hours af "neturef", or	15. Deced (Specify only high	ent's Education nest grade completed)	(Give k	nt's Usual Occupation ind of work done during most of	f working 16b	Kind of Business/Industry	
d 21215-0 filed within 72 hos Hygiene. ther then "neture out, the Wester I	Elementary/Secondary (0-12	) College (1-4or 5-	+)	NOT use retired)		Home	
yland  ould be fife Mental Hy arked othe attic event,	17. Father's Name (First, Middl	e, Last)		18. Mother's	Name (First, Middle, Maid	len Sumame)	
Baltimore, Maryland permit. Pages 1 and 2 should be lift Department of Health and Mental Hy Important: If them 27 is marked oth enty injury or other treumatic eventone.	19a. Informant's Name/Relatio	nship (Type, Print)	19b. Mailing	Address (Street and Number	or Rural Route Number, Cit	y or Town, State, Zip Code)	
Te, N 1 and 1 Health tem 27 other tr	Brenda Sc 20a. Method of Disposition	ivell/dou	Shiely 695 20b. Place of Disposi	tion (Name of	nill hd	Barry Day De Location - City or Town, Sta	12/15 te
altimore, mit. Pages 1 a partment of Nez portent: if Item y injury or othe		n 3 □Removal from State (Specify)	Metro C	atory or other place)	-23-0x B	am, oth	
Balt permit. Departr Imports eny inju	21. Signature of Funeral Service	ce License		Name and Address of Facility	han. h	7 200	ouzd
	23a. Part1. The disease, shock of eart failure. L	or complications that caused ist only use on each lin	the death. Do not enter	the mode of dying, such as ca	rdiac or respira ory arrest,	Jesser H	
Physician. /Medical	Immediat ause (Final disease or condition resulting in death)	- Brain	DOAT	4		Onset	and Death
Examiner		Due to (or as a	consequence of):	landona	hemorr ha	eros 12	-hrs
execute and iat-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	tone (m)		12	has
		C. Due to (or as a	consequence of):	TENSION			1
6876 tificate be g physicii as the bu		d					
P.O. Box 687 nat the death certificate by the attending phys etached for use as the Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		Ectopic pregnancy		23d. Date of delivery  Month Day	Year
P.O. E	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5 🗌	Other (specify)		WiGitti Day	1 6 4 1
S, as as as as as as as as as as as as as	Part II. Other significant cond	itions contributing to death but	nt not resulting in the und	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause	e of death?
If Records, The law requires t cate has been signe page 2 should be completed by	COLONAL	y Artory	1 DUS	£0	24a. Was an autopsy performed	24b. Were autopsy find prior to completion death?	
Vital F sicien: Th certificate irector, pag	25. Was case referred to medi	cal		26. Place o		No 1 ☐ Yes 2 ☐ No	
Of VI Physicie this cert ral direct	1 ☐ Yes 2 No	Hospital: 1 Inpatier 28a. Date of Injur	the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa		ng Home 5 Residence		
ion inding lath.	1 Natural 5 Pen 2 Accident inve	/Afrath Pau	Year) Injury	28c. Injury at Work? M 1 □ Yes 2 □ No		ilary occurred	
Division of Vital Rec To the Hospitel or Attending Physicien: The taw within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	3 Suicide 6 Cou 4 Homicide dete	ld not be mined 28e. Place of Inju building, etc	ry - At home, farm, stree . (Specify)	et, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route ate)	Number,
thin 24 hour thin 24 hour the Funer mpletely fill		ying Physician: To the best of al Examiner: On the basis of and manner sta	examination and/or inve	occurred at the time, date and estigation, in my opinion, death	place, and due to the cause occurred at the time, date	o(s) and manner as stated. and place, and due to the car	1 <b>se</b> (s)
To ti withii To ti comp	29b. Signature and title of cert	ler 1	202	29c. License number	29d.	Date signed (Month, Day, Ye	ar)
	30. Name and address of pers	on who completed cause of de	eath (Item A3a) (Type, P	12/16		10/12/2	2005
3	Bon Secondary, Ye	orsteapita	r's Signature	timoro, 20	00 west	BALtimoro	24
State Registrar	MAY 1	9 2005 Sugar	, If Age	de la			

	•	For State Registrar		I / Department of Hea Certificate of De		, ,	g. No. 0 0 5	1687
<b>.</b>		1. Decedent's Name (First, Middle, I	ast)	0		Date of Death		3. Time of De
Physicia /Medica		Patrick	Thomas	Cur	rin	Month May	Day Ye	005 0231
Examine		4a. Facility Name (If not institution, g		4b. City, Town, or Loc	ation of Death	1 (4)	4c. County of E	
Examine		The Johns	Hopkins Hospin	tal Baltimo	re Cit	Y	1	1/12
Funeral			Sex 7. Age (In vrs. la			,	9.	Birthplace (State or F
Director		167-48-5533	XX м 2□F 49		ours Min.	Date of Birth (Month, Day, 0-7-19	79 <i>ar</i> ) 55 0	Birthplace (State or F Country) klahoma
>	-	Usual Residence of Decedent  10a. State 10b. County	100 City	Taum and another				1
sho ta d	-	,		Town or Location				10d. Inside City I
Ba-1	5	PA Washir	igton Mo	cDonald, PA				1 Tes 2
armen of Health and Menial Hygiene.  Artent: If Item 27 is marked other than "natural", or Items 23e or 28e-f show  njury or other traumatic event, It is Maxical Examilier is and be notified at	Funeral Director	10e. Street and Number 813 Valley Str	eet	10f. Zip Code 15057			g. Citizen of Wha USA	t Country?
ns 2	era	11. Marital Status	12. Was Decedent Ever in U.S	13 Was Decedent of Hispar	nic Origin? (Specify	Ves or No-	14 Bace	American Indian.
Iten	5	1 Never Married 2 Married	Armed Forces?	<ol> <li>13. Was Decedent of Hispar If Yes, specify Cuban, M</li> </ol>	lexican, Puerto Rica	in, etc.)		Vhite, etc.
0	by F	3 Widowed 4 Divorced	If Yes, Give	1 ☐ Yes 2 🔀 No Sp	pecify:		Specify:	Libita
ural Ex	9		Year or Dates:					White
"nat	Completed	15. Decedent's (Specify only highest of	Education grade completed)	<ol> <li>Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)</li> </ol>	n ng most of working	1	6b. Kind of Busine	ess/Industry
nar.	ם	Elementary/Secondary (0-12)	College (1-4or 5+)					
Hygiene. ther than	ဂ္ဂ	12		Technical Supe	rvisor		Medica	.1
d off	Be	17. Father's Name (First, Middle, La	st)	18.	Mother's Name (Fi	rst, Middle, M	aiden Sumame)	
and Mental F	၉	Thomas M	arshall Currin		Dolores	M. Her	man	
nd h		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street and I				te, Zip Code)
th a		Cynthia Currin	Wife					
Hea am than		20a. Method of Disposition		813 Valley St:	Date		Oc. Location - City	
Department of Health a Important: If Itam 27 is any injury or other tra		1X Burial 2 ☐ Cremation 3		metery, crematory or other place)	l		oc. Location - City	or rown, State
ant:		'4 ☐ Donation 5 ☐ Other (Spe	cify) Rob	inson Run Cemete:	ry 5-11-0	5 M	cDonald,	PA 15057
Port Port		21. Signature of Funeral Service Lo	er/see /	22. Name and Address of	Facility	р	asadena,	MD 21122
Depo any once			1/2	Stallings Fo	uneral Ho	me PA	3111 Mou	nrain koad
		23a. Parti. Enter the visease, or co	malications hat caused the death.					Approximate
		23a. Par I. Enter the visease, or co shock, or heart filure. List on	ly one cause on each line.					Interval Betwee
nysician		Immediate Cause (Final disease or condition	Sma	Il bowel Ob	struction	1		2 wee
Medical		resulting in death)	Due to (or as a conseque					T out of
xaminer		Cognostially list and disease	b Oro	thelial Carci	noma			A menu
-09	ē	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque					· POLITI
ansi	Ē	Cause (Disease or injury						1
hysician and he burial-transit	Examiner	resulting in death) Last	Due to (or as a conseque	ence of):				
iciar	cai							
the			d					
ing 6	Me	IF FEMALE:						
attending phy	Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of				23d. Date of	delivery
d fol	<u>5</u>	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of dea				Month	Day Yea
ed by the a	Š	9 🗆 Unknown	9□ Unknown					
det.		Part II. Other significant conditions	contributing to death but not result	ting in the underlying cause given in	Part I.	23e. Did toba	acco use contribut	te to the cause of dea
w -	by					1 ☐ Yes		Probably 4 Uni
signed be det	ĕ .					1 100	2,4110 0	
een signe	-					24a. Was an		autopsy findings ava
as been signe 2 should be	piet					autopsy perform	ed? deat	to completion of caus h?
been sign	ompiet							
ificate has been signe or, page 2 should be o	Completed	25. Was case retarred to madical						Yes 2□No
certificate has been signe rector, page 2 should be e	Be	25. Was case referred to medical examiner?	Hospital:	Other	Place of Death (C)	hack only one	)	
his certifica	To Be	examiner? 1 D Yes 2 No		R/Outpatient 3 DOA Cther: 4	Place of Death (Cl	heck anly ane 5 □ Resider	oce 6 Other (S	
his certifica	To Be	examiner? 1 □ Yes 2 □ No  27. Manner of Death	1 Vinpatient 2 LE	Other	Place of Death (Cl	heck anly ane 5 □ Resider	)	
n, After this certificate has been sign funeral director, page 2 should be	To Be	examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year)	R/Outpatient 3 DOA Cther: 4	Place of Death (Cl	heck anly ane 5 □ Resider	oce 6 Other (S	
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Ifer death. Director: After this certificate has been sign in by the funeral director, page 2 should be	To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	28a. Date of Injury (Month, Day Year)	P/Outpatient 3 DOA Cther. 4 28b. Time of Injury M Work? M 1 Yes	Place of Death (Classification) Nursing Home 28d. 2 \( \subseteq No \) 28f.	beck only one 5 ☐ Resider Describe how	oce 6 Other (Se injury occurred	Specify)
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amend item#23a, permp, 6844.6/8/05 11 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year May 17, David 2005 DeWitt 9:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3727 Boyd Drive Edgewater Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 2,1934 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10XM 2□F 185-26-5510 71 Yrs. Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2\OXNo MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3727 Boyd Drive 21037 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify White Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Warren DeWitt Nan Rodie 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Stonebrook (Wife) 3727 Boyd Drive, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/19/2005 ^ 4 □ Donation 5 □ Other (Specify) Metro Crematory Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A 21. Signature of Foneral Service Lices Dallas 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each primary Amyloidosis. Approximate Interval Between Onset and Death Immediate Cause (Final MUST disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home sesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

certificate be executed Box 68760 P.O. Records. Division of Vital

To the Hospital or Attanding Physician: within 24 hours a To the Funerel C

**Funeral** 

Director

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Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) MAY 1 9 State Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

Medical

1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. HomiLTON, MP

32 Registrar's Signature

DUFOUTY

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maliner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D41698

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registramend item #1 per phy 8843 5/19/19/19/19 Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death **Physician** Month Day AURING KEBECCA dos 1.20A M /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PKID NA OhNS 5. Social Security Number (In yrs. 24 Hrs. 8. Date of Birth (Month, Day, Year) August 20,1923 Age **Funeral**  Birthplace (State or Foreign Country) Days 1□ M 2 🔀 F Months 225-30-7588 81 Hours Yrs **Director** VA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County rai', or items 23s or 28a-f show Examiner must be notified at 10d. Inside City Limits MD Montgomery Director Deerwood 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15832 Deerwood Road 20855 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 SNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ∰Widowed 4 □ Divorced "natural", er than "natura Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) is marked Caude Kirk Lennie Mae Flanary 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Dale Eldridge /Son 1708 Tweed Street Rockville, MD 20851 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 = 0 May 5, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Jonesville, VA Flanary Family Cemetery ⁴ 4 □ Donation 5 □ Other (Specify) 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave. Baltimore MD 21230 23a. Part1. Enter the disease, a complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician WOARACHNOIC dAVS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☑Unknown plnods 1 □ Yes 2 □ No been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No s certificate has blirector, page 2 s 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 1 ☐ Yes 2 ☑ No - B 7 1- Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day Year, 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1- Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined efter 4 / Homicide

Division of Vital Records, P.O. Box 68760 To the Funeral Director: After th completely filled in by the funeral within 24 hours e To the Funeral I To the Hospital

Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600

31. Date filed (Month, Day, Yea MAY 1-9

29b. Signature and title of eartifier

29a. Certifier

32. Registrar's Signature

North

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

WOLFE Start Baltinose, Mcd. 21287

29d. Date signed (Month, Day, Year) may 2,2005

			For State Registrar	State of Maryland / L	Certificate of Death		I Hygien Reg. N		10001
	Physicia	an	1. Decedent's Name (First, Middle, Last)	0.05		Mor			3. Time of Death 2:45 AM
	/Medic Examin	al	Devora M. E 4a. Facility Name (If not institution, give s	<del></del>	4b. City, Town, or Location	of Death		C. County of Death	2142 /1 M
	LXdiiiii	C.	0 0	H05p.	Baltimo			NA	
	Funeral Director		210 10 1200	11 -00/-	thday) If Under 1 Year If Under Months Days Hours	Min. 8 Date	e of Birth nth, Day, Year LNDL 3	9. Birthpl	ace (State or Foreign
	yland sow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location			10	Od. Inside City Limits
	Ba-fsh	ctor	Maryland N/A	Bal	timore				1 X Yes 2 □ No
	ath with th	Funeral Director	3819 ROVENWOOD	Avenue	10f. Zip Code 2/2/3		U	itizen of What Count	-ates
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show says injury or other traumatic event, Ite Madical Examinat must be notified at once.	þ	11. Marital Status  1. Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1 Tyes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic On If Yes, specify Cuban, Mexica 1 ☐ Yes 2 No Specify		s or No- etc.)	14. Race - America Black, White, e Specify: Bl	
Maryland 21215-0036	1 within 72 h jiene. r than "natu ire Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation 16a.  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)	est of working	1 7.	Kind of Business/Ind Wr5ing A	tome
yland	should be filed nd Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) RICKARD EPPS			per's Name (First, EV Fie C		n Sumame)	
	and 2 sho ealth and I n 27 is mu		19a. Informant's Name/Relationship (Type Linda Turner-	Sister 38		AVE ILUL		or Town, State, Zip	
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition  1  Burial 2	. comota	Disposition (Name of ry, crematory or other place)	May Date 21		ocation - City or Tov	4
Balt	permit. Departr Importe sny in		21. Signature of Funeral Service License	Willing	22. Name and Address of Facility D. U. But 1165	Baltin	1	rice, P.A. Laryland	31339
	SUSTEEN ST		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death. Do e cause on each line.	not enter the mode of dying, such as	s cardiac or respira	atory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	and law	we			
	Examiner		Sequentially list conditions.	netal	rollie Acid	osis			
$\mathcal{T}$	pet usit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of).				
60,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a consequence	of):				
68760,	ificate g physi as the b	edicai	d						
P.O. Box	The law requires that the death cert ate has been signed by the attendin, page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliver Month	ry Day Year
	s that the	by Ph	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part	1. 236	e. Did tobacco	use contribute to the	e cause of death?
ords	w requires that been signed to should be det	ted b	Crohns a	usease Co	vreinoma C	olon	1 ☐ Yes 2	2 □No 3 □ Proba	ıbly 4 □Unknown
of Vital Records,		Completed		,			a. Was an autopsy performed?  Yes 2 N	prior to com death?	ssy findings available inpletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		ce of Death Check			
n of	ing Phys Ifter this Ineral di	on; To	1 ☐ Yes 2 💢 No ''  27. Manner of Death  1 🛣 Natural 5 ☐ Pending	28a. Date of Injury 28b.	Firme of 28c. Injury at mjury Work?	28d. De	Residence scribe how inju	6 ☐Other (Specify, ury occurred	)
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At home, fa building, etc. (Specify)	M 1 ☐ Yes 2 ☐ trm, street, factory, office	28f. Loc	ation (Street a	nd Number or Rural te)	Route Number,
	s Hospita 24 hours e Funeral	edical C	29a. Certifier 1 Certifying Phys (Check only one)	icien: To the best of my knowledge er: On the basis of examination an and manner stated.	e, death occurred at the time, date a d/or investigation, in my opinion, de	and place, and due eath occurred at the	to the cause( e time, date ar	s) and manner as stand place, and due to	ited. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	PHYSICIAN	29c. License number			ate signed (Month, D	
)			1		D 575			-17-03	
-	2		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print) W. BALTIMORE	ST, B	ALTIN	nore, N	1021223
	Sta Registr	_	31. Date filed (Month, Day, Year) MAY 1 9 2005	32. Hegistrar's Agnature	SEL				

	•	1 - For State Registrar	State of Ma		partment of F ertificate of			giene) (	05	16882
Div		1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dea Month	Day	Year	3. Time of Death
Physici /Media		Beringo Gonzales					May 13,			11:30 p M
Examir	- 1	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	or Location of Death	h	4c. Coun	ty of Death	
	2	Future Care Cherr	ywood		Reisters			Balti		
Funeral		Social Security Number     6.	NVM 2DE	e (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	h /, Year)	9. Birth	place (State or Foreign ntry)
Director	9	456-12-4471	8	1 Yrs			Feb. 13	, 1924	Tex	
and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location					10d. fnside City Limits
Aaryl F sho	5	MD Baltimo	- Table 0	Owings	Mills					1 ☐ Yes 27 No
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with with			Danielana Ameri	412				USA		•
leath	Funeral	9773 Groffs Mill  11. Marital Status	12. Was Decedent I Armed Forces?		13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S	Specify Yes or No-		ace - Amer	can Indian,
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il Z I 3-UU30 within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-1 show fre Marical Exercities matter collines an	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	41-45	1⊠XYes 2□No		lexican	Spec		xican
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yiand ould be file Mental Hy arked oth	Be	17. Father's Name (First, Middle, Las	it)			18. Mother's Nar	me (First, Middle,	Maiden Suma	ame)	
Via ould Men arke	2	Andrew Gonzales				Rosette		Boles		
OTC, MATYIAI es 1 and 2 should b of Health and Ment fitem 27 is marked r other treumetic e		19a. Informant's Name/Relationship	(Type, Print)		ailing Address (Street					p Code)
and and lealth m 27		Dena R. O'brien	Daughter		nardon Cou	rt Reiste				
OTO Frof H If its		20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3	☐Removal from State	cemetery,	isposition (Name of crematory or other pla	1	Dafe	20c. Location	n - City or I	own, State
Pag ment ant:		*4 □Donation 5 □ Other (Spec	ify)	Garriso	n Forest V		5/18/05	Owings	Mill	s, MD
baltimore permit. Pages 1. Department of He Important: If its any injury or oth		21. Signature of Funeral Service Lice	on see		22. Name and Addre		11824 F			
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		23a. Part1. Enter the disease, or con shock, or heart failure. List only	npfications that caused y one cause on each lir	the death. Do not ne.	enter the mode of dy	ng, such as cardiad	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	meso	thelion	n9					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequence of)						
CXAIIIIIEI	L	Sequentially list conditions,	b							
10 ±	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of)						
ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence of)					-	
<b>68 / 6U,</b> ificate be ex g physician as the burial			Due to (or as	a consequence or						
physi the I	dical	•	d							
	Physician/Med	IF FEMALE:	23c. ff yes, outcome	of pregnancy				024 5	Taka af dali	
BOX sath cer attendir for use	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetaf death	3 Ectopic pregnand 5 Other (specify)	;y			Date of delivery Jonth	Day Year
the de by the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	timo di dodan	3 - Ciriar (apociny)					
IS, P.	Ph.	Part If. Other significant conditions	contributing to death b	ut not resulting in th	ne underlying cause gr	ven in Part I.	23e. Did to	obacco use co	ntribute to	the cause of death?
dS,	d b	Parkinson's	Disease				10	res 2 No	3 🗆 Pro	bably 4 Unknown
VITAI HECOTGS, sician: The law requires t certificate has been signe rector, page 2 should be o	Completed by						24a. Was	244	More aut	opsy findings available
He lay	E D	Hy pertensi	01)				autop		prior to co	ompletion of cause of
			T				1 ☐ Yes	2 19 No	1 🗆 Yes	2 No
rf VITAI HE nysician: The la nis certificate has I director, page 2	Be	25. Was case referred to medical examiner?	Hospitaf:		0		ath (Check only o			
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DIVISIO  Tor Attendi after death.  Director: A	fica	3 ☐ Suicide 6 ☐ Could not	bo	ury - At home, farm	, street, factory, office		28f. Location (5	Street and Nur	mber or Ru	ral Route Number,
after Dire	erti	4  Homicide determine	building, et	c. (Specify)			City or Tov	vn, State)		
DIVISION Of VITA To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying I	Physician: To the best	of my knowledge, o	teath occurred at the t	ime, date and place	e, and due to the	cause(s) and	manner as	stated.
• Ho 24 h • Fu letely	edical	(Check only 2 Medical Exone)	aminer: On the basis o and manner st	f examination and/	or investigation, in my	opinion, death occu	urred at the time,	date and place	e, and due	to the cause(s)
To the within 7	Me	29b. Signature and title of certifier	0 :			se number		29d. Date sign	ned (Month	Day, Year)
		> Yacen &	pabritt	M.D.	DC	05867	16	may	16,	2005
1 4		20 Name and address of pareon up	o completed cause of o	leath (Item 23a) (Ti	(no Print)	***				
61		Karen Babit	+, M.D. , 2	15 Main	street, s	uite 20	p, Reis	ters to	ת חנת	1D 21136
St	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	sole!					

			1 - State Registrar	State of M	aryland / D	epa <i>Cen</i>	rtment of H tificate of I	lealth and M D <i>eath</i>		ene () ()	5   6883
	Physici	an	1. Decedent's Name (First, Middle, Las	•					2. Date of Death Month	Day Y	3. Time of Death
	/Medic	al	Andrew  4a. Facility Name (If not institution, give	Joseph			4h City Town as	Location of Death	May 1	7, 2005	6:30 PM
	Examin	er	1311 Old Fall			1	Falls			Hari	
	Funeral		Social Security Number     6. S		ge (In yrs. last birt		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, APR 19,		9. Birthplace (State or Foreign
	Director		232-44-6957 Usual Residence of Decedent	W.M. 207	75	Yrs.			APR 19,	1930	West Virginia
	ryland how		10a. State 10b. County		10c. City, Town	or Loc	ation				10d. Inside City Limits
	Be-f e	Director	Maryland Harford					llston			1 □Yes 2 No
	with t		10e. Street and Number 1311 Old Fallsto	n Road			10f. Zip Code	1047	10	g. Citizen of Wh	•
	death	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W		ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-	14. Race -	SA American Indian,
36	n 72 hours after death with the Maryland "natural", or items 23a or 28e-f ehow gistal Examinat must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces' 1 XYes 2 I If Yes, Give	1951 <b>-</b> 53	1	Yes 2 No	Specify:	rican, etc.)	Specify:	White, etc.
Maryland 21215-0036	2 hour	ted b	15. Decedent's Ed	ucation		Decede	ent's Usual Occupa	ation during most of worki	1	6b. Kind of Busin	White ness/Industry
215	드	Completed	(Specify only highest gra	de completed) College (1-4or	5+)	iife. D	O NOT use retired	"	ng		
121	e filed with If Hygiene. other than vent, the N		17. Father's Name (First, Middle, Last)		S:	idi	ng/Roofin	ng 18. Mother's Name	/First Middle A		ruction
land	should be independent of marked of matic eve	To Be	George Hrib						Sapp	alderi Surname)	
lary	2 should I and Meni is marker eumatic	-	19a. Informant's Name/Relationship (7	Гуре, Print)	19b.	Mailing	Address (Street a	and Number or Rura	I Route Number,	City or Town, St	ate, Zip Code)
	s 1 and 2 should if Health and Mer Item 27 is marke other treumatic		Teresa M. Miller/	Daughter	20h Place of		11 Old Fa	allston Ro		lston, N	
nor			20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		cemeter	y, crem	atory or other plac	e)			ity or Town, State
Baltimore,	그 돈 돈 글 .		21. Signature of Funeral Service Ocen		Metro	Crer	Name and Addres	Inc. 5/19	/U5	Baltın	more, MD
ä	permi Depa Impo any ii	2 1	Edward A. Cre	gorchik		29	99 Freder	ick Road	Baltimo	nc. re, MD 2	21228
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that cause one cause on each I	ine.			g, such as cardiac c	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Lu	a consequence of	NC	er				2-3 yrs.
	Examiner		Convention line and discon	b Due to (or as	a Consequence C	, נוכ					0
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	of):					
	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence o	of):					_
68760,	ysiciar ysiciar ne buri	edical E		d							
		Med	IF FEMALE:								
Вох	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date of Month	•
Ö.	at the de by the itached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		-			71		
S, P	res that igned to be det	by	Part II. Other significant conditions of	ontributing to death I	out not resulting in	the un	derlying cause give	en in Part I.			ute to the cause of death?
ord	w requir been si should	eted							1 2 Ye		Probably 4 Unknown
Record	The law cate has I page 2 s	Completed							24a. Was ar autopsy perform	prid led dea	ere autopsy findings available or to completion of cause of ath?
ital		a	25. Was case referred to medical					26. Place of Death			Yes 2 No
of Vital	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati		tpatient	3□ DOA Othe	4   Ivuising noi	me 5 Reside		
	ng fter ine	tion:	27. Manyer of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, Da	ury 28b. T uy Year) Ir	ime of njury	28c. Injury Work	/at <br Yes 2 □No	28d. Describe ho	w injury occurred	
Division	el or Attending s after death. si Director: After ed in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At home, far	rm, stre			28f. Location (Str	eet and Number	or Rural Route Number,
Ö	itet or irs afte rei Dir led in	Cert	,		tc. (Specify)				City or Town		
	To the Hospitel or A within 24 hours after To the Funerel Directonpletely filled in by	Medicai	29a. Certifier 1	ysician: To the best niner: On the basis of and manner s	of examination and	, death d/or inve	occurred at the time estigation, in my of	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and mann te and place, and	ner as stated. d due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29c. License				Month, Day, Year)
	/	19	Im Luc.	ne, MI	)			05499		May 18,	, 2005
	5	i//	30. Name and address of person who	3901 =	death (Item 23a) (	Type, P	amed.	a Ba	It, M	1 212	18
	Sta	te	31. Date filed (Month, Day, Year)	A. Regist	rar's Signature	110	1071 C W.	, , , , ,	, ,		
	Registr	ar	MAY 1 9 200	O Allower	A. A.	7284	a)		<u> </u>		

Brendan Hall 05-03166 RPD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

IJΙ	.00		For State Registrar	State of I	Maryland		artmen rtificate				Mental Hy	/giene	7	5	16884
	Physici	an	1. Decedent's Name (First, Middle	, Last)							2. Date of De		v v	ear	3. Time of Death
	/Medic		BRENDAN GREGORY								May 7	, 20°	05 '	<del>0</del> a1	0313 A M
	Examir	ner	4a. Facility Name (If not institution	*	er)				Location of	of Death			. County of		
			Laurel Regional  5. Social Security Number	~	A // /	4 6 1 a 6 a 6 a 1 a 1	Laun If Under		lf Under	Od Uro	1				rge's
	Funeral Director		217-27-3345	6. Sex 7.	Age (In yrs. las	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Date of Bi MAY 5, 1	rth a <i>y, Year,</i> 98.1	9	. Birthpl Coun MARYI	lace (State or Foreign try) _AND
	pue *		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Lo	cation							14	0d. Inside City Limits
	d within 72 hours after death with the Marylend liene. r then "natural", or tems 23a or 28e-1 ehow the Medical Examinar must be notified at	ō		E GEORGE's			· oution							'	1X Yes 2 No
	286-	Director	MD PRINC 10e. Street and Number	E GEURGE S	LAUF	KEL	10f. Zip	Code				10a. Ci	tizen of Wh	at Coun	
	3a or	Ö	16115 JERALD ROAD					707				US			.,,.
	death	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	13.	Was Deced	lent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	0-	14. Race -		
98	or ite	正	1 🕅 Never Married 2 ☐ Marri			1	1 Tes, spec 1 ☐ Yes 2		Specify:	i, Pueno	Hican, etc.)			White, 6	_
8	hours ural',	d by	3 Widowed 4 Divorced	Year or Date									Specify:	WHI	
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212	iene. r than	Completed	Elementary/Secondary (0-12) 12	College (1-4d	or 5+)		RACT SE					DEP	T. OF	DEFEN	ISF
ğ	Hyg the int,	Bec	17. Father's Name (First, Middle,	Last)						r's Nam	e (First, Middle			<u> </u>	
Maryland 21215-0036	should be ind Mental marked o	To E	RAYMOND B. HALL						EILE	EN M.	. RAKOWSK	Υ			
lan	ges 1 and 2 should il of Health and Men if Itam 27 is marke or other treumatic		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rur	al Route Numb	er, City	or Town, Sta	te, Zip	Code)
ر د د	is 1 and 2 of Health a litem 27 is other tree		RAYMOND HALL / FAT	HER	anh Blo-				AD, LA		MARYLAN				
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Ħ	글 본 원 글 .		' 4 ☐ Donation 5 ☐ Other (S <sub>k</sub> 21. Signature of Fugeral Service I		IVY		EMETER'			/11/2	-		EL, MA		ND
Ba	Depa impo any i		> Halm	1. 4300		22	. Name and 7€01 S				ECK FUNE				7
8760, <	Cate be executed // Medical Examiner the burial-transit	licai Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to minimal data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Cue to (or c.	as a consequent	nce of):	NJ U	C.je	<b>3</b> 3						Interval Between Onset and Death
.O. Box 6	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal de at time of death	ath 3	Ectopic pre						23d. Date o Month		y Day Year
rds, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditio	ns contributing to death	n but not resultin	ng in the ur	iderlying ca	luse give	n in Part I.		23e. Did t		. /		a cause of death?
Vital Record	The law ate has b page 2 sh	Completed									24a. Was autor perfo		prio	r to com	sy findings available apletion of cause of
/ita	Physicien: Th this certiticate ral director, pag	Be	25. Was case referred to medical examiner?							of Deatl	h (Check only o		1		
of	Physic this c	2	1X Yes 2 No	Hospital: 1 🗆 Inpa		/Outpatien			4 LI NUI	-	me 5 Resi			Specify)	
OU C		ion	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	1	Day Year)	b. Time of Injury		Bc. Injury Work		,	28d. Describe			(0)	TRES
isi	Attending r death. actor: Attel by the tune	licat	2 Accident investig 3 ☐ Suicide 6 ☐ Could n	ot bo	100	207	M factory	1 🗆 Y	es ZVI		28f. Location (	•			LISION WITH
Division	atter Dire	Certification;	4 ☐ Homicide determi		Injury - At home etc. <i>(Specify)</i> A D 0 W		et, lactory,	Onice			City or To	wn, State	)		LAURSL HD
	To the Hospitei or Attend within 24 hours atter death To the Funerei Director: completely tilled in by the	edical C	(Crieck only 2XXMedical E	Physician: To the be xaminer: On the basis	st of my knowled of examination	dge, death	occurred a	at the time	e, date and	d place.	and due to the	cause(s)	and manne	er as sta	ted.
	To the l within 2. To the I	Med	29b. Signature and title of certifier	and manner	stated.			License					e signed (A		
)	F 3 F 8		Man - d	ma (1/6.00	) · ka	^	200.	OC					7, 20		-y, rour/
•	-1		30. Name and address of person v	the completed cause of	death (Item 23	la) (Tyne	Print)		- 11.1			ray	7, 20	<u> </u>	
	8		MARYARITA	A. KORE	"LC			Penn	Stre	et	Baltim	ore,	Mary	lanc	1 21201
	Sta Registr	6	31. Date filed (Month, Day, Year)	2005 32 Regis	strar's Signature	- Land	de								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** Annie Ruth Harding May 13, 2005 8:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6505 Falston Road Elkridge Howard If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F Director 557-34-5603 Yrs 81 Alabama Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. The Medical Examinar must be notified at Director tXXYes 2 □ No MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6505 Falston Road 21075 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ⚠ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry 1.2 should be filed within 7.2 h and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marcus Shearin Louise Fink 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Item 27 is n any injury or other traun 2005. Dorothy A. McKinley/Daughter 15649 Millbrook Lane, Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Union Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 5/16/2005 Burtonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00773 Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY **Physician** EARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COR PULMONALE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): attending physician Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 menths? 4☐ Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ HYPERLIPIDEMIA HYPERTENSION 1XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 XNatural death. 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year, D38296 May 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h Joseph F. Gibbons, MD 9501 Old Annapolis, Suite 202, Ellicott City, MD 2. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar 9 2005

			1 - For State Registrar	State of Marylan		artment of F tificate of				16886
ı	Dhusisi		Decedent's Name (First, Middle, La	st)		involto or	Dour	2. Date of Dea	Reg. No. ath Day Ye	3. Time of Death
	Physici /Medic	cal	CLIFTON	HOOD,	5R			MAY	16 200	05 845AM
	Examin	ner	4a. Facility Name (If not institution, give 2926 Potts	- //	0		Cu. 11		4c. County of D	TMore
	Funeral		Social Security Number 6.3	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of Birtl	h Yearl 9.	Birthplace (State or Foreign Country)
	Director		316-32-5936 - Usual Residence of Decedent	M 2□F 67	Yrs.	Worldis	riodis iviai.	nov 21,	1937	MS
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Be-f si	Director	MD BAL	Timore		SRKUILLE				1 Yes 2 No
	with the	Dire	10e. Street and Number	11:11 11.11		10f. Zip Code	. 1 2 1/		10g. Citizen of Wha	-
	death with the Maryland ms 23a or 28e-f show roust be notified at	Funerai	2926 PUTTY	12. Was Decedent Ever in U. Armed Forces?	.S. 13.1	Vas Decedent of h	139 Hispanic Origin? (Sp	pecify Yes or No-	U · 5,	American Indian.
0000	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "naturel", or litems 23a or 28e-f show event, the Medical Examination unit an political at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cub I□ Yes 22 No	an, Mexican, Puèrd Specify:	Rican, etc.)	Black, V	White, etc.
o o	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	lent's Usual Occup	pation during most of won	kina	16b. Kind of Busine	ess/Industry
7	within ene. than	idmo	Elementary/Secondary (0-12)	College (1-4or 5+)		. 0	during most of world)  UCRCR		Mechani	ee /181. 5
א מ	e filed Il Hygi other	a	17. Father's Name (First, Middle, Last		1	THE CO			Maiden Sumame)	ics union
yaı	2 should be and Mental is marked c	To B	Dorice Hood				NORMA	ST	Reib	
Mar	d 2 sh th and 7 is m treum		19a. Informant's Name/Relationship (		19b. Mailir	g Address (Street		-	r, City or Town, Sta	
ē,	ges 1 and 2 should it of Health and Mer If item 27 is marke or other treumatic		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	Hill Ave	Date Date	to Mo 3 20c. Location - City	V or Town, State
Ē	Pages nent of I ent: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the C	Themoval from State	: 4 V ( Ed.)	natory or other pla CremaTo	SEY 3/1	7/05	Balto.	MD
Baltimor	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Lice		14	Name and Addre	ess of Facility  1. UCR -5	Tella Fo	nern 1 /t	1234
ľ	+		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Lung	Ca	ncer				Onset and Death
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09/00,	ificate be executed g physician and as the burial-transit	al E		Due to (or as a consequ	uence or):					
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X O O	wrequires that the death certif been signed by the attending should be detached for use as	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	Ideath 3	Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
	The law requires that the death to has been signed by the atter bage 2 should be detached for u	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5□	Other (specify) _			Wichter	Ody Feat
Į.	s that gned b	by Pf	Part II. Other significant conditions	contributing to death but not resi	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
ecords,	equire							1414	′es 2 □ No 3 □	Probably 4 Unknown
ပ် မ	e law has b	ompieted						24a. Was a autop: perfor	sy prior	e autopsy findings available to completion of cause of
VIGIL		e Co	25. Was case referred to medical				Of Place of Dec	1 Tes	20 No 10	
>	ding Physicien: h. After this certific funeral director,	To B	examiner? 1 🗆 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Ott	26. Place of Dea	1.	ence 6 Other (	Specify)
io ui	ling Pt		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Woo		28d. Describe h	ow injury occurred	
VISION	death death ctor: y the	ertification;	2 Accident investigatio 3 Suicide 6 Could not b	Blace of laive. At he	ome, farm, str		Yes 2 □No	28f. Location (S	itreet and Number o	r Rural Route Number,
	s after el Dire ed in b	Certi	4  Homicide determined	building, etc."(Specif)	Y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow		
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) Certifying Physics Medical Example (Check only one)	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the til restigation, in my o	me, date and place, ppinion, death occur	and due to the c red at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the vithin To the comp	Ž	29b. Signature and title of certifier			29c. Licens	se number	2	111	Ionth, Day, Year)
	6		1 ///m	1			12 4.12		5/10	(e)
	V		30. Name and address of person who	completed cause of death (Item	1 23a) (Type,	tartore	a Ro	Bal	timore	MO 21224
1	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 9 2005	32. Registrar's Signa	don't	,			-	-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. JET 05-03420 State of Maryland / Department of Health and Mental Hygiene Larry Hagisavas State of Maryland / Department of Health and Mental Hygiene Larry Hagisavas Unpend Item 23a,27,28a-f per me G844 6-9-05 tas

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year HAGISAVAS -ARRY /Medical 2005 1:55 Mav 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1701 Cherry Hill Road Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 10M 20 F 217-13-6247 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö AUR 21214 items 23a 2311 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "naturali, or Ite 1⊟Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: WhiTE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WORKED 12 NEVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HAGISAVAS LAMBRAKIS JULIE JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLOUILLE AVE BALTO. MS JULIZ JOHNSON 2311 212.14 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of himportant: If ite any injury or of 1 Burial 2 Cremation 3 Removal from State 119105 BAYVIEW CremaTORY \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STELLA FUNELAL HOME HARTILY MILLER - STELLA FUNELAL HOME 7527 hartery R.D. BALTO. MS 20234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Methadone intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ng physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy of in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9☐ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, sign 4 Dunknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼ Yes 2 □ No 24a. Was an autopsy performed? 1X Yes 2□No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X ther (Specify) (Scine) 1 √ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury **Found**, Day Year) **5-17-05** 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After unk 1 Natural 5 Pending Found investigation 1 ☐ Yes 2 X No 2 Accident after death Director: 1:20 6 X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 1701 Cherry Hill Rd. 4 Homicide Scene Baltimore, 124 hours at Md 29a. Certifier 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mid OCME 18 2005 Mav 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LI. LING 111 Penn Street Baltimore Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 9 2005 DHMH 17 Rev 1/2001

**ORIGINAL** 

	-V-1	4	1- State of Maryland / [	-	artment tificate			nd M		giene Reg. No.	005	16888
	Physicia /Medic	al .	1. Decedent's Name (First, Middle, Last) Beverly J	. н	ock1e	у			2. Date of Dea Month	Day	200 Z	10 st W
ı	Examin	er	4a. Facility Name (If not institution, give street and number) Levindale Nursing Center		Ba.	ltim			0	1	County of De	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X 7. Age (In yrs. last bin 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number 72 Number	thday) Yrs.	If Under 1	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day August	h Year)	1932	Birthplace (State or Foreign Country) Maryland
	Maryland -f show	tor	10a. State									10d. tnside City Limits  MXYes 2 □ No
	h with the	Funeral Director	10e. Street and Number 3803 Conduit Avenue		10f. Zip (	Code 1211				-	zen of What	Country?
036	urs after deat al', or Items 2 Examiliation	by Funera	11. Marital Status  1 Never Married 2 Married  3 Wyvidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:		Was Deceder f Yes, special		spanic Orig , Mexican Specify:	gin? (Sp <i>e</i> , Puerto f	cify Yes or No- Rican, etc.)		Black, Wi	merican Indian, hite, etc. White
21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene d other than "natural", or tems 23a or 28a-f show event, the Medical Evatricational to codiffed a	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  10th	(Give	dent's Usual kind of work DO NOT use OMEMA	k done di e retired)	tion uring most	of workir	ng	16b. Kir	Own	•
Maryland	be od o	To Be C	17. Father's Name (First, Middle, Last) William Wren						(First, Middle, et Whee		Sumame)	
	1 and 2 sho Health and I Iem 27 Is me other traums	·	Sharon DeVor (Daughter) 8	14	Welli	ngto	n Str		Balto		Town, State	
Baltimore,	Pages nent of ant: If it		20a. Method of Disposition  1  Burial 2XX remation 3 Removal from State  4 Donation 5 Other (Specify)						8/2005		cation - City	or Town, State MD
Balt	permit. Departr Importa any inj		21. Signature of Juneral Service Licensee)	uneral lto, Ml	) 21	e, Inc 1211	•					
	Physician /Medical	Ų.	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence	lv	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
V '09/	rate be executed by sician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence c. Due to (or as a consequence c.		el	Fr	uli	re				7/10/10
Box 687	res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 [	Ectopic pre	gnancy				2	3d. Date of o	delivery Day Year
P.O. E	at the des d by the all etached fo	Physic	1   Yes 2   No 9   Unknown 9   Unknown		Other (spe				00, 014			
Records,	The law requires that the ste has been signed by the bage 2 should be detached.	b	Part IJ. Other significant conditions contributing to death but not resulting i	n the ui	nderlying ca	iuse give	n in Paπ I.				No 3	to the cause of death?  Probably 4 Inknown
	ician: The law certificate has brector, page 2 st	e Completed	25. Was case referred to medical				00 Pl		1□ Yes	med?	24b. Were prior t death 1 \( \triangle Y	
f Vital	Physicia this cert al direct	To B	examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	ıtpatien	it 3□ DO/	A Othe			<i>(Check only o</i> ne 5□ Resid		Other (S)	pecify)
Division of	ttending Pt death. stor: After th	atlon:		Time of	M 28	c. Injury Work	at ? 'es 2 □ l		28d. Describe I	now injury	occurred	
Divis	ospital or Atte hours efter de uneral Directo ly filled in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, str	eet, factory,	office		2	28f. Location (S City or Tox			Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.	e, death	occurred a vestigation,	it the tim- in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)
!	To t Withi	Σ	29b. Signature and title of certifier			License				29d. Date	signed (Mo	onth, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a)	43	sy r	2 Be	livel	ine	aus	- , 3	alha	-0200;
	Sta Registr	_	31. Date filed (Month, Day, Year) () 32. Registrar's Signature MAY 1 9 2005	do	de la							

			For State Registrar	State of M	aryland / Depa		of Health a			gienę () ()	5 16889
			Decedent's Name (First, Middle, Last	)					2. Date of Dea	th	3. Time of Death
	Physici		Lerov E.	Jackson					Month	16, 2005	12:18 P <sup>M</sup>
	/Medic		Leroy E.  4a. Fecility Name (If not institution, give			4b. City, Toy	wn, or Location	of Death	lay	4c. County of [	
	Examin	er					ambrills			Anne	e Arundel
	Funeral	-	980 Annapolis Roa  5. Social Security Number 6. Se		ge (In yrs. last birthday)	If Under 1 Y	ear If Under	24 Hrs.	8. Date of Birth (Month, Day		Birthplece (State or Foreign Country)
п	Funeral Director		497-12-0306 X	DM 2□F	85 Yrs.	Months D	ays Hours	Min.	July 21		Missouri
			Usual Residence of Decedent								
	how how		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	B Ma	cto	Maryland Anne Aru	ınde1	<u> </u>	Gambr:	ills_				1 ☐ Yes 2 No
	or 28	Oire	10e. Street and Number			10f. Zip Co	ode			10g. Citizen of Wha	t Country?
	23a	Funeral Director	980 Annapolis Ro	ad			1054			United	
	ams	ie i	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent If Yes, specify	t of Hispanic Or. Cuban, Mexical	igin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)	14. Race - / Black, V	American Indian, Vhite, etc.
36	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show ita Maulgal Examinar masi ke mulified at	y F	1 Never Married 2 Married	1▼ Yes 2 ☐	No	1 ☐ Yes 2 <b>%</b>	No Specify:	:		Specify:	
21215-0036	ural	d by	3 Widowed 4 Divorced	Year or Dates:		dent's Usual C	\				White
5	"nat	Completed	15. Decedent's Edu (Specify only highest grad	ie completed)	(Give		done during mos	st of worki	ng	16b. Kind of Busin	
12	withir	Ę.	Elementary/Secondary (0-12)	College (1-4or	5+)		,			bureau o	f Engraving
	filed Hygin other		12th 17. Father's Name (First, Middle, Last)		50	pervis		er's Name	(First, Middle,	Maiden Sumame)	
an	Mental Hygi Mental Hygi erked other atto event, I	o Be	Jesse L. Jac	kson				Myrt1	Le A.	Mack	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Meulical Exercitive fixes in cliffied at	10	19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (S				r, City or Town, Sta	te, Zip Code)
Ma	d 2 sho		Gary Richard Jacks			2.5	is Road			, Marylan	
	1 and Health em 27 other tr		20a. Method of Disposition	5011/ 5011	20b. Place of Dispo	sition (Name	of		ate	20c. Location - City	
õ	Peges nent of int: If It iry or o		1 Burial 2 Cremation 3 1		West Arun	-		5/17	7/2005	Odenton	, Maryland
Baltimore,			* 4 □ Donation 5 □ Other (Specify,								
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1	BL sister		23a. Part Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final			ter the mode o	f dying, such as	cardiac o	r respiratory ari	rest,	Approximate Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	u	helioma s a consequence of):						8 Months
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6	uted	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events								
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89	ificat g phy as th		_								
Box	ires that the death certifica signed by the attending ph d be detached for use as th	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregr				23d. Date of	
	death e atte d for	Icla	in the past 12 months?	4 Pregnant a		Other (speci				Month	Day Year
0	oy the	hys	9 Unknown	9□ Unknown							
٩,	s tha	y P	Part II. Other significant conditions co	intributing to death	but not resulting in the u	inderlying caus	se given in Part	1.	23e. Did to	bacco use contribu	te to the cause of death?
rds	quire in sig uld b	pa							1 🗆 Y	es 2√ΩNo 3[	Probably 4 Unknown
Records,	s been si	olet							24a. Was a		e autopsy findings available
	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Completed by Physician/Med							autop perfor	med? deat	r to completion of cause of th? Yes 2⊠rNo
Division of Vital		BeC	25. Was case referred to medical				26. Plac	e of Death	Check only o	A	X ZX
>	ysician: is certific director,	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpat	ient 2 ER/Outpatie	nt 3 DOA	Other			lence 6 Other	Specify)
o	g Phys er this eral di	n:	27. Magner of Death	28a. Date of Inj (Month, D	ury 28b. Time o		Injury at Work?	[	28d. Describe h	ow injury occurred	,
ion	nding th. :: Aft	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year) Injury	М	1 Yes 2	No			
Vis	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of ir	njury - At home, farm, st	reet, factory, o	ffice	1	28f. Location (S City or Tow		or Rural Route Number,
Ö	Hospital or Attending Physician: 14 hours after death. Funeral Director: After this certification by the funeral director.	Certification:	4   Homicide	bundang, e	itc. (Specify)				011, 01 7010	n, olalo)	
	pspit hours uners y fille	) al			t of my knowledge, deat						
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Exam	and manner s	of examination and/or in tated.			a(II OCCUFF		- 10	
	To the within To the comp	Σ	29b. Signature and title of certifier	0.080000			icense number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		29d. Date signed (A	Month, Day, Year)
			Inonh	ay N	1.0		039	50	5	Mary	17,2005
	IKA		30. Name and address of person who o	completed cause of	death (Item 23a) (Type,	Print)	0		Cla	May Bum	10
	[0],		Indhish 1	ranko	m 305	Hosp	ited D	V .	year	MD.	2:061
		ate	31. Date filed (Month, Day, Year)	2. Regis	trar's Signature	el -					
	Regist	rar	MAY 1 9 2005	Alenda	A Page	es.					
				-	-						

			1 - For State Registrar	State of Mary			of Health a of Death	nd Mental H	ygiene Reg. No.2	05 [5890
ı	Physic	ian	1. Decedent's Name (First, Middle, La. Chester Francis K					2. Date of D	Day	Year 3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give			4b. City, Tow	m, or Location of	May 11		y of Death
			15701 Tasa Place			Laurel			1	ce George
	Funeral Director		5. Social Security Number 6. S 213-44-3073	ex 7. Age (In 60	yrs. last birthday) Yrs.	If Under 1 Y	ear If Under 2 ays Hours	Min. 8. Date of E	20, 1945	9. Birthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent					Materi	20,1743	Масусана
	the Marylan 28a-f show notified et	ō	10a. State 10b. County		c. City, Town or Lo	ocation				10d. Inside City Limits 1 \( \overline{\pu} \) Yes 2 \( \overline{\pu} \) No
	r 28a-f	rect	Maryland Prince ( 10e. Street and Number	seorge L	aurel	10f. Zip Cod	de		10g. Citizen of	
	th with 23e or	aD	15701 Tasa Place			20707			u.s.A.	,
	72 hours after death with the Maryland neture!', or items 23e or 28a-f show ited Exarti at must be multiped at	Funeral Directo	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent If Yes, specify (	of Hispanic Origi Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Rai Bla	ce - American Indian, ick, White, etc.
036	ours aft	by	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢	No Specify:		Specia	y: White
21215-0036	72 hours "neturel",	Completed	15. Decedent's Ec		16a. Dece	dent's Usual Oc kind of work do	ocupation one during most o etired)	of working	16b. Kind of B	dusiness/Industry
121		dwc	Elementary/Secondary (0-12)	College (1-4or 5+)	Devel		etired)	-	Real Es	stato
d 2	e filed Il Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)	-	vevec	oper	18. Mother	s Name (First, Middi		
ylaı	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the M.	To E	Chester Francis Ko	····				s Pearl Co		
Maryland	nit. Pages 1 and 2 should be filed within carinnent of Health and Mental Hygiene. carient: if item 27 is marked other than injury or other traumatic event, the Me.		19a. Informant's Name/Relationship ( Patricia Kopicki					or Aural Aoute Num aurel, Mar		
	s 1 an if Heal item 2 other		20a. Method of Disposition	2	0b. Place of Dispo			Date Date	-	- City or Town, State
Baltimore,	Page ment c ent: if ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State  /)  Bi	altoWa	sh. Crei	matory !	5/16/2005	Laurel,	Maryland
Balt	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tra ance.		21. Signature of Funeral Service Licen		22	2. Name and Ad	ddress of Facility	Fleck Fun	ieral Hon	ne, Inc.,
			23a. Part1. Enter the disease, or comp	olications that caused the				and the same		Lyland 20707
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	144	et a	-,,			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):	MA				4 YEARS
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	nsequence of):					
V	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.						
90,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):					
68760,	ficate to physical street.	edlca		. d						
Вох	h certii ending use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		7F at a = 1 = 1 = 1 = 1			23d. Da	te of delivery
.O. B	The law requires that the death certific tle has been signed by the attending p tage 2 should be detached for use as:	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time		Ectopic pregna Other (specify			Mo	onth Day Year
P.	that the ed by detacl		Part II. Other significant conditions or	ontributing to death but no	t resulting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use cont	tribute to the cause of death?
Records,	iw requires that s been signed b should be deta	ed by							Yes 2,⊠No	3 Probably 4 Unknown
oco	e taw re has bee je 2 sho	Completed						24a. Wa		Were autopsy findings available prior to completion of cause of
		Con							ormed?	death?
Vital	Physicien: The this certificate rai director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	0[[[[]]]			f Death (Check only		
of	ding Phys .r After this funeral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien  28b. Time of Injury	t 3□ DOA 28c. I	4 □ Nurs njury at Work?	ing Home 5 Res 28d. Describe	how injury occur	
sion	Attending r death. ector: After by the fune	catlc	1			M 1	Yes 2 No			
ā	i or Attencatter death Director:	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, str oecify)	eet, factory, offi	ce	28f. Location City or To	(Street and Numb own, State)	per or Rural Route Number,
	To the Hospital or Attending Ph within 24 bours atter death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Ph. 2 Medical Examone)	ysician: To the best of my iner: On the basis of exa and manner stated.	knowledge, death mination and/or inv	n occurred at the restigation, in m	e time, date and i ny opinion, death	place, and due to the occurred at the time	cause(s) and ma , date and place,	inner as stated. and due to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier				ense number			d (Month, Day, Year)
			Jan O Jan	ملكم			17390			7005
	148		30. Name and address of person who o	completed cause of death		Print 45	13 BA	etimoile:	MO 212	-31
	Sta Registr		31. Date filed (Mooth, Day, Year) MAY 1 9 2005	32. Registrar's S	ignature	D				

			1 - For Amend Item Registrar	State of 23a-b&25	Maryland/Dep per me G843 <sub>e</sub>	artment of F	lealth and I	Mental Hyg	iene 005	16891
	Dharaia		1. Decedent's Name (First, Middle,					2. Date of Death		3. Time of Death
	Physic /Medi		Donna Kells					MAY	16 2005	- 16:50 M
	Examir	ner	4a. Facility Name (If not institution,				r Location of Deatl	A) 1	4c. County of Deat	h
	Funeral		5. Social Security Number		TIMO(UE 7. Age (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	9 Bird	hnlace (State or Foreign
	Director		212-70-6395	1□M 210 F	48 Yrs.	Months Days	Hours Min.	(Month, Day,		hplace (State or Foreign ountry) yland
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Li	ocation				10d. Inside City Limits
	the Maryland r 28a-f show	ţō	Maryland		Baltim					1 ☑ Yes 2 ☐ No
`	ith the or 28a	Directo	10e. Street and Number			10f. Zip Code		10	og. Citizen of What Co	untry?
5	th w 23a	raiD	4100 Boarman Av	enue		2121	5		U.S.A.	
	er death v Items 23a	Funerai	11. Marital Status	Armed For	ces?	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
036	urs aft	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ☐ Yes If Yes, Give Year or Da	tes:	1 ☐ Yes 2 ☐ No	Specify:		Specify: Bla	ack
5-0036	72 hours "natural", adical Ex	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occup	ation	ting	16b. Kind of Business/	
2121	within ene. than *	mpi	Elementary/Secondary (0-12)	College (1-	4or 5+) life.	DO NOT use retired	1)	ning	36 34 3	
3 2	be filed withl ital Hygiene. id other than event, the M	Co	12 17. Father's Name (First, Middle, La	ast)	Nurs	ing Assis		ne (First, Middle, M	Medical	
an .	ould be Mental parked o	To Be	Willie Kells					Ganney	alden dumame)	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Manallone.	-	19a. Informant's Name/Relationship	o (Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State, 2	Tip Code)
-	is 1 and 2 should of Health and Men frem 27 is marke other traumatic		Michael Kells /	Son			venue, B	altimore,	Maryland	21215
Baltimore,	000-		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Removal from S	20b. Place of Dispo cemetery, creaters	sition (Name of matory or other plac	e)	Date 2	20c. Location - City or	Town, State
ξĒ			* 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Li		Mr. Zion	Cemetery	05/2	1/2005 La	indsdowne,	Maryland
Ba	permit. Departr Imports any inju		21. Squature of Purietal Sprivice Life	11366		C 1 1 D1-	The	Derrick	C. Jones 1	F/H, P.A.
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that ca						Approximate
	Physician		Immediate Cause (Final disease or condition	ny one cause on ea	SEPSIS					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (c	or as a consequence of):					170003
	Lxammer	_	Sequentially list conditions,	b	Renal insu	ficiency		- //	10	
_	red nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	or as a consequence of):			All	2	
, G	be executed slcien and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (c	or as a consequence of);			AL EXAMIN	EH	
8760	ate be executed hysicien and the burial-transi	dicai		d			OVE	BY MEDICAL EXAMIN		
9	ertifica ling ph e as tl		IF FEMALE:	-			ECATION APPINO			
Вох	death certific e attending pl d for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir		Ectopic pregnancy			23d. Date of deli Month	very Day Year
o.	that the de ed by the detached	iysic	1 □ Yes 2 No 9 □ Unknown	4∐Pregna 9☐ Unkno		Other (specify)				
0	res that igned b	by Pr	Part II. Other significant condition	s contributing to dea	ath but not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
of Vital Records,	~ 01 0	ed b	Alcohol Abuse	SGIZUTE	disorder, F	tsthma	Anomia,	1XYes	s 2□No 3□Pro	obably 4 Unknown
မင္ပင	law as b	Completed	Hapatity C					24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
= H	Th ate pag	Соп	,					perform 1 Yes 2	ed? death? XNo 1□Yes	2 100
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 🛶		045		th (Check only one	)	
o		1: To	27. Manner of Death	28a. Date of	patient 2 ER/Outpatier	and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th	4 Nursing H	ome 5 Resider	nce 6 Other (Spec	ify)
ion	Attending F r death. ector: After by the funer	atior	1 Natural 5 Pending investigation	(Month	, Day Year) Injury	Work	(?` Yes 2 □ No		injury occurred	
Division	r Attendi er death. rector: A	Certification;	3 Suicide 6 Could no determine	ad 28e. Place o	of Injury - At home, farm, str g, etc. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru.	ral Route Number,
	ital o urs aft rat Di iled in								ŕ	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying (Check only one) Medicel Ex	Physician: To the taminer: On the base and manner	pest of my knowledge, death sis of examination and/or in	n occurred at the time vestigation, in my op	e, date and place, pinion, death occur	and due to the cat red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	Fo the vithin Fo the comple	Me	29b. Signature and title of certifier	and manne	51 5(4(80).	29c. License	number	29	d. Date signed (Month	, Day, Year)
	/		1 Yeur		MD	CES	-040	7	Jan 16 20	15
	5		30. Name and address of person wh	o completed cause	of death (Item 23a) (Type,	Print)	-		lay 16 20 BALTIMOR	
			1GATHERINE	MiTu	THE MD	SINAI	1+05pi	FAI OF	BALTIMO!	e
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 9 2	005 37 Re	gistrar's Signature	WE .	•			
				-	19					

			1 - For State Registrar	State of Maryla	-	artment of H			giene () ()	5	168	92
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time o	f Death
	/Medic		EMMA	RUTH	K	ATZ		MAY 1	6, <sup>Day</sup> 2005		8:23	АM
	Examin	ner	4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, or			4c. County	of Death		
	Formul		SINAI HOSPITAL  5. Social Security Number 6. Sex	7 Age /la vi	rs. last birthday)	If Under 1 Year	BALTIMOR If Under 24 Hr		h	9 Birtho	N/A	or Foreign
	Funeral Director		057-05-8124	M 0005	39 Yrs.	Months Days	Hours Mir		1915	Coun	place (State htry)	USSIA
	pu ,		Usual Residence of Decedent									
	show	5	10a. State 10b. County		City, Town or Lo					1	0d. Inside C	
	286-1	Director	MD BALTIMO	DRE	OWINGS				10. 00.			2 No
	hours after death with the Maryland tural, or Items 23a or 28e-1 show at Exart, art must be rudilised at	급	8015 TOWNSHIP DRIVE	- #2 P		10f. Zip Code	21117		10g. Citizen of \		ISA	
	death ms 23	Funeral		2. Was Decedent Ever in	U.S. 13. 1	Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No-	14. Rac	e - Americ		
٥	or ite	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		_		nto Rican, etc.)	Blac	ck, White,		
5-0036	irai',	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify	· W	HITE	
7	hin 72 hours after death with the Marylan 3. In "natural", or Items 23a or 28e-1 show Medical Exami me must be redilled at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done of	furing most of w	orking	16b. Kind of B	usiness/Inc	dustry	
2	E T S Ki	m d	Elementary/Secondary (0-12)	College (1-4or 5+)	ACCOU	DO NOT use retired	)		۸۲۲	ITNUC	NC	
ט ס	filed Hygi ther ent,		17. Father's Name (First, Middle, Last)		ACCOU	MIAMI	18. Mother's Na	ame (First, Middle,			Nu	
/land	should be nd Mental marked c	To Be	ISIDORE		DAVIDS	ON	IDA				HELFA	ND
Mary	2 sho and Is mu reum		19a. Informant's Name/Relationship (Typ		2.	ng Address (Street a					Code)	
	s 1 and f Health item 27 other t		SHEILA DERMAN / DAL  20a. Method of Disposition		9 WI . Place of Dispo	LLWOOD CO	JURI - B	Date	20c. Location -		um Ctata	
و	e = 5		1 XBurial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crer	natory or other place				-		n
altimore,	permit. Pa Departmen importent: any injury once.		*4 ☐ Donation 5 ☐ Other (Specify)  21. Sign turn 1 Funeral Service Lonse			EMORIAL F	-		RANDAI			J
n	permit Depart import any in	ļ	MAINLAND	Sugar		Name and Addres REIST						208
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the de						ا وعاء.	Approxima	te
,	Pnysician :		Immediate Cause (Final disease or condition	2 × 1		0	. 1/-	·			Interval Bei Onset and	Death
	/Medical		resulting in death)	Due to (or as a cons	equence of):	NIL DI	سه ۱۱ ۲۰	The.				
	Examiner		Sequentially list conditions. b.	Due to (or as a cons	esis							
	Sit 9d	lner	Sequentially list conditions, if any, leading to immediate cause. Unter underlying	Due to (or as a cons	uence of):					291		
	and I-tran	Examlne	cause. Litter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	to an	idosis					
g/60,	cate be executed physicien and the burial-transit	ᄪ		urun	equation of).	lutar	1000	1.10				
28	cate ohy the	edical	d.			- 0-	مريمن	re co				
Xog	that the death certifi ed by the attending i detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of preg					23d. Dai	te of delive	irv	
	death e atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☑ No	1☐Live birth 2☐Fe		Ectopic pregnancy Other (specify)			Мо			Year
r Ö	at the by th	hys	9 Unknown	9□ Unknown								
ທົ	S 75 0	by	Part II. Other significant conditions cont	ributing to death but not r	esulting in the u	nderlying cause give	en in Part I.		bacco use cont			/
Hecord	w require been sig should b	ompleted	11 5 th hate	1 0 0 -				1 U Y	es 2 No	3 Proba	ably 4	Iknown
န္ င	e taw has b	nple	- thiel	fibrulati				24a. Was a autop	SV I	Vere autop	psy findings npletion of c	available cause of
	icate har, page	O						perfor 1 ☐ Yes		death?	2□ No	
VItal	Physician: The faw this certificate has t al director, page 2 s	o Be	25. Was case referred to predical examiner?	ospital:	_/_	• 20 DOA Othe		ath Check onl or				
ō	£	-	1 Yes 2 No	28a. Date of Injury		28c. Injury	at Nursing	Home 5 Resid			)	
UNISION	tending leath. tor: Afte the fun	ertification;	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work M 1□1	:? /es 2 □ No	1				
<u> </u>	r Atte	rtflc	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str	eet, factory, office		28f. Location (S City or Tow		er or Rura	Route Nur	iber,
	oitel ours af	O						1				
	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier Certifying Physi (Check only one)	cian: To the best of my ker: On the basis of exami and manner stated.	nowledge, death nation and/or inv	n occurred at the tim vestigation, in my op	e, date and place pinion, death occ	e, and due to the curred at the time, of	ause(s) and ma late and place,	nner as sta and due to	ated. the cause(:	3)
	ro the	Me	29b. Signature and title of certifier	2 1		29c. License	number	2	29d. Date signer	1 (Month, I	Day, Year)	
	~	-	) N to C	Belle 1	D.	1	31615	_	5/16	105		
1	1		30. Name and address of person who con	npleted cause of death (It	em 23a) (Type,	Print)	walk		/		Α.	
			Habre Grand	Beston	00	15	wall	En 1	Ane	Kirl	To.	mis
	Sta Registr		31. Date filed (Month Day, Year) 2005	32. Registrar's Sig	nature April	W)				-	2160	8

			1 - For State Registrar	State of Maryland			of Health <i>of Death</i>			giene Reg. No	UUU	15	893	3
	Physici	an	Decedent's Name (First, Middle, L.	,					2. Date of De Month	aath Da	y Ye	ar	ime of Dea	ath
	/Medi		Betty	Н.	Lei	ghto				10	200	5 9	pm	М
	Examir	ner	4a. Facility Name (If not institution, gi				own, or Location	of Death			. County of D			
			1554 Chapman		- A 5-1-4- 1- 1- 1-		fton	a O.4 Han			Anne A			
	Funeral Director			Sex 7. Age (In yrs. Ia: 1 ☐ M 2 🖾 F 8 4	st birthday) Yrs.	If Under 1 Months (	Days Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	9.	Birthplace (S Country)	State or Fo	reign
			Usual Residence of Decedent	04				1	July 8	, 19	20   E	ngland	i	
	/land		10a. State 10b. County	10c. City,	Town or Loc	cation						10d. Ins	ide City Li	mits
	Man	ţ	MD Anne A	rundel Cro	ofton							10	Yes 2	XNo
	r 288	Director	10e. Street and Number	010	JICOII	10f. Zip C	ode			10g. Cit	izen of What	Country?		
	h witi	<u>=</u>	1554 Chapman Ro	ad			21114				USA			
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	. 13. V		nt of Hispanic O Cuban, Mexica	rigin? (Spe	cify Yes or No	)-	14. Race - A		ian,	
9	or ite	臣	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give			No Specify		Hican, etc.)			/hite, etc.		
8	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examilier must be rotified at	d by	3√√Widowed 4 □ Divorced	Year or Dates:		L 163 20	ALINO Specify	·.			Specify:	White	3	
5	"nati	Completed	15. Decedent's E (Specify onty highest gi		16a. Deced (Give I	ent's Usual ( kind of work	Occupation done during mo retired)	st of worki	ing	16b. K	ind of Busine	ss/Industry		
12	within ene. then *	g.	Elementary/Secondary (0-12)	College (1-4or 5+)			retired)							
d 2	Hygie Hygie other		17. Father's Name (First, Middle, Las	<u> </u>	Actr	ess	18 Moth	ner's Name	(First, Middle,		neater			
Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked other then aumatic event, the M	o Be	William H. Menh								Sumame			
<u> </u>	should nd Me mark mati	은	19a. Informant's Name/Relationship		19h Mailin	a Address (S	Street and Numb		eth Per		Town Stat	- 7i- C- d-1		
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at		Amanda McCusker				nan Road					e, 21p Code)		
ē,	of Health item 27 i		20a. Method of Disposition			sition (Name natory or other			ate OILOIL,		cation - City	or Town, Sta	ate	
30	0 0		1 ☐ Burial 2 🌠 Cremation 3 ( `4 ☐ Donation 5 ☐ Other (Speci	Ji torriovar from State				:/1/./	2005					
Baltimore,			21. Signature of Foreral Service Lice	A	22	emator Name and	Address of Eacil	5/14/ lity			timor	D 4 1	1 A .	
B	permit. Departr importe any inju		1 Satt 4	6111	Н	ardes	sty Fu	nera	1 Home	Р.	A. Anr	NIUge Annald	⊥y Av	٠.
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	applications that caused the death.	Do not ente	r the mode o	of dying, such as	s cardiac o	r respiratory a	rrest,	AIII	Appro	ximate	
	Physician		Immediate Cause (Final	one cause on each line.		. 1			•			Interv	al Between and Death	1
1	/Medical		disease or condition resulting in death)	a. Due to (or as a conseque		سااد	re					tu	rele	1
	Examiner			Conce	chie	110	east	Fa.	Lune			130	102-T	45
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):	• /		, (	000 00					
/	cuted nd ransi	Examiner	triat iriitiated events	C										
ó	an ar		resulting in death) Last	Due to (or as a conseque	nce of):									
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	•	d										
9	ing pl	Med	IF FEMALE:											
Вох	eath certific attending p for use as t	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de		Ectopic pregr	nancy			2	23d. Date of	-		
o o	at the dea by the a tached for	Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of dear 9☐ Unknown	th 5□	Other (speci	fy)				Month	Day	Year	
۵.	requires that the een signed by th hould be detache	Phy	Part II. Other significant conditions	contributing to double but not requisi-	ing in the	4-4-4			20 - 0:44					
ds,	ires tha signed I be dei	by	Tatti. Ottor significant conditions	commutating to death but not result	ing in the un	derlying caus	se given in Part	1.	230. Did to		se contribute			
0	w requir been si should	etec							101	res 24	<b>Q</b> No 3□	Probably	4 Unkno	wn
3ec	2 S a	Completed							24a. Was autop	SV	prior	autopsy find to completion	ings availa	ible of
of Vital Record		3							1 Yes	rmed? 2 X No	death			
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				e of Death	(Check only o	ne)				
o	Phys this ral dii	. To	1 ☐ Yes 2 No  27. Manper of Death	1 □ Inpatient 2 □ EF	VOutpatient		<del>'</del>	ursing Hon			Other (S	pecify)		
n	ding After fune	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	8b. Time of Injury	M 28c.	Injury at Work?		8d. Describe h	iow injur	y occurred			
S	or Attending after death. Director: After in by the funer	ical	2 Accident investigation 3 Suicide 6 Could not be	O COO Diese of Initial Athan	o farm stro		1 Tes 2		OPf Location /6	Time to a	el Alexandra e e e	B ( B	A1 6	
Division	i or A after Dira	Certification;	4 Homicide determined	building, etc. (Specify)	e, iaiiii, sire	et, factory, of	HICO		28f. Location (S City or Tow	vn, State,	)	rurai route	Number,	
	Hospital 24 hours a Funeral I stely filled	C	29a. Certifier 1 Certifying Pl	nysician: To the best of my knowle	edne death	Occurred at t	ho time date as	nd place a	and due to the					
	To the Hospital or Atten within 24 hours after deat to the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Exal	miner: On the basis of examination and manner stated.	n and/or inve	estigation, in	my opinion, dea	ath occurre	ed at the time,	date and	place, and d	ue to the cau	use(s)	
	To the within 2 To the Complet	Me	29b. Signature and title of certifier			29c. Li	icense number			29d. Date	e signed (Mo	onth, Day, Ye	ar)	
			100	E Tarlos IX 1	nn	D	00332	296		<	-/11	105		
	0,	-	30. Name and address of person who	completed cause of death (Item 2)	3a) (Type, P									
	1		Neil E Pade	en 7711 Qu	in Kit	Reld	RD G	len	Burk	* e r	11)2	1061		
	Sta	- 7	31. Date filed (Month Pay Year) 20	Registrar's Signatur	· Soos	E.								
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			For State Registrar	State of Mary	-	artment of H		d Mental Hy	giene 0 0	5	6894
			1. Decedent's Name (First, Middle	, Last)				2. Date of De	ath		3. Time of Death
	Physici /Medic		Joseph	Albert		Logan	SR.	Month May	12,2005	Year	1 AM M
	Examir		4a. Facility Name (If not institution			4b. City, Town, or			4c. County o	f Death	
			927 Autumnwo	od Drive		Gambri	i 1 <b>1</b> s		Anne	Arund	le 1
	Funeral		5. Social Security Number		yrs. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bin (Month, Da	th Year	9. Birthplace	e (State or Foreign
	Director		027-12-4163	XIXM 2□F 80	Yrs.	MOINTS Days	nours	Nov. 8			chusetts
	p ,		Usual Residence of Decedent  10a. State 10b. County	140	c. City, Town or Lo						
	shov	2									Inside City Limits
	Ba-f	Scto		Arundel (	Gambrills						1 ☐ Yes 2√XNo
	with t	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country	?
	s 23	rai	927 Autumnwood				054		USA		
	er da	une	11. Marital Status	12. Was Decedent Ever Amed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin' ın, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	b- 14. Race Black	- American   White, etc.	
5	filad within 72 hours after daath with the Maryland Hygiena. Uther then "naturel", or Items 23a or 28a-f show ant, It in Medical Examerational Lean affilied at	by F	1 ☐ Never Married 2 ☐ Marri 3 ※ Widowed 4 ☐ Divorced	ed 12/□X/es 2 □ No If Yes, Give Year or Dates:		1□Yes 2X No	Specify:		Specify:	Whi	ite
3	hou	ed	15. Decedent		l 16a Dece	dent's Usual Occupa	ation		16b Kind of Bun	in a se de de se	-
2	n "n	piet	(Specify only highes	grade completed)	(Give	kind of work done of DO NOT use retired	during most of	working	16b. Kind of Bus	1110025/1110025	пу
7	iena.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Princ	·	,		Educa	tion	
3	Hyg othe ent,	a)	17. Father's Name (First, Middle, I	ast)			18. Mother's	Name (First, Middle			
2	lid ba lenta kad ic ev	To B	Charles Logan				Ve	ronica G	2 rm11 c		
<u> </u>	shound M	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailir	ng Address (Street a		r Rural Route Numb		tate, Zip Co	de)
Ž	nd 2 alth a 27 Is		Susan Bachmann	(Daughter)				, Gambril			,
ก	s 1 a if Hei item othe		20a. Method of Disposition	20	b. Place of Dispo		1	Date	20c. Location - C		State
2	Page ento nt: If ry or		1 Burial 2 Cremation 4 Donation 5 Nother (Sp	3 □Removal from State ecity) EptombmentR			' I	17/2005	Brentwo	od MT	`
altillo	permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Department of Health and Mental Hygiena. Important: If item 27 Is marked other then. Instruction: If item 27 Is marked other then. Instruction of the standard of the page of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the		21. Signature of Fundral Service L		00	Name and Addes	4 F384				
Ď	Depar Impore eny ir		Valt A la	1/(	H a	rdesty	Funer	al Home	P+A+Ann	anolis	s. MD21401
-	95		23a. Part1. Enter the risease, or shock, or heart failure. List of	complications that caused the	death. Do not ent	er the mode of dying	g, such as car	diac or respiratory a	rrest,	Ap	proximate
	Physician		Immediate Cause (Final	only one cause on each line.	comia						erval Between iset and Death
	/Medical		disease or condition resulting in death)	aDue to (as a con	sequence of):	0					auys
	Examiner										
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):						
	outed id ransii	Examiner	Cause (Disease or injury that initiated events	c							
Ć,	an ar	EX	resulting in death) Last	Due to (or as a cor	sequence of):						
9	sate be executed obysician and the burial-transit	dicai		d							
0	death cartifica attending ph d for use as th	Med	IF FEMALE:								
20	th ca tendi	hysician/Me	23b. Was decedent pregnant	23c. If yes, outcome of pr		Ectopic pregnancy			23d. Date	,	
	e dea he at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time		Other (specify)			Mont	n Day	y Year
י ב	at the i by to etach	Phy	9 Unknown								
ñ	res that the death car igned by the attendin be detached for use	by	Part II. Other significant condition	is contributing to death but no	t resulting in the ur	nderlying cause give	en in Part I.		obacco use contrib		
2	w requir been si should	ted	/ ena/	Tarrore				_ 1□	Yes 21 No 3	Probably	√ 4 ∐Unknown
נ ט	law las be	ompieted	_ diabet	s mellitu	15			24a. Was	an 24b. We	ere autopsy	findings available
	ilcien: The lav certificate has rector, page 2	Соп						perfo		ath? Yes 2	etion of cause of
<u> </u>	clen: artific actor,	Be (	25. Was case referred to medical examiner?					Death (Check only o			
-	Physic this or al dire	2	1 ☐ Yes 2 No		2 ER/Outpatien	t 3□ DOA Othe	er: 4 ☐ Nursin	ng Home 5 Hesi	dence 6 Other	(Specify)	
=	ding P	on:	27. Manner of Death  1 Statural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how injury occurred	í	
<u>2</u>	tendi leath tor: A	cati	2 Accident Investig 3 Suicide 6 Could n	at bo			/es 2 □ No				
2	or At fter d Siract in by	ertification;	4 Homicide determine		At home, farm, str pecify)	eet, factory, office		28f. Location (. City or To	Street and Number vn, State)	or Rural Ro	oute Number,
1	urs a	0	00- 0	- The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the				1			
	To the Hospitel or Attending Physicien: The law requires that the death cartificate be executed within 24 hours after death.  To tha Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	29a. Certifier (Check only one)  Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discourse Certifying Discour	Physician: To the best of my xaminer: On the basis of examiner	knowledge, death mination and/or inv	occurred at the time restigation, in my op	e, date and pl pinion, death o	ace, and due to the occurred at the time,	cause(s) and manr date and place, an	er as stated d due to the	d. cause(s)
	ithin ; o tha	Mec	29b. Signature and title of pertifier	and manner stated.		29c. License		T	29d. Date signed (		
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	, 0	1	20 Name and addition of	to completed and a state of	(lto= 02s) (T		17	//	0///	1/17	
	10		30. Name and address of person v				C+	3 MD 0111	,		
	Sta	te.	Paul Berez, MD 31. Date filed (Month, Day, Year)	1655 Crof	ignature 4		rorton	, wn Sili	4		-
	Registr	-	MAY 1 9 21	005 Mark	K Span						
				7							

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death					
			1. Decedent's Name (First, Middle, Las			2. Date of Dea	ith	3. Time of Death
	Physic		June L	oveless		MAY	Day Year	1405 M
	/Medi Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	. 7 63
1			7802 Chesi	UUT AUC	PARKVIlle		BALT	Mone
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday)		8. Date of Birth	9. Birthpl	ace (State or Foreign
	Director		313-30-4294	M 200 74 Yrs.	Months Days Hours Min.	June 30	(, Year) Count	MA
	pu ,		Usual Residence of Decedent					
	aryla shoy	_	10a. State 10b. County	10c. City, Town or Lo			10	Od. Inside City Limits
	88-1	cto		LTIMORE	PARKUILLE			1 ☐ Yes 2 No
	or 2	Dire	10e. Street and Number	-	10f. Zip Code	1	log. Citizen of What Count	ry?
	ath w	rai	7802 Chesno	TAVE	21234		U.S. A	•
	er de	nne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America Black, White, e	
36	s afte	by Funeral Director	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	,		
215-0036	within 72 hours atter death with the Maryland ene. then "retural", or llems 23a or 28e-f show hadical Examera must be notified at		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			Specify: Wh	
7		Completed	15. Decedent's Edi (Specify only highest grad	de completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	16b, Kind of Business/Inde	ustry
212		E C	Elementary/Secondary (0-12)	College (1-4or 5+)	CLERK		STATIONERS	1-00
	filed Hyg other		17. Father's Name (First, Middle, Last)	~(1)	18. Mother's Nam			CORP.
an	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelin and Mental Hygiens.  If if me m 27 is marked at the then "netural", or litems 23a or 28e-1 show it if item 27 is marked at the most is marked at the most is a constant in a marked at a constant in a marked at or other treumatic event, it is Marileal Examinating must be notified at	To Be	JACOB BOW	ien		Knaun		
Maryland		-	19a. Informant's Name/Relationship (T		ng Address (Street and Number or Run			Codel
Z			Charles Lovele		CHESNUT AVE			4
อ์	s 1 a f Hee Item othe		20a. Method of Disposition					
Baltimore	Pages nent of I ant: if its ary or o		1 ☐ Burial ,2 ☐ Cremation 3 ☐ I  `4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	matory or other place)	6/00	P. 11 0.0	
₹			21. Signature of Funeral Service Licens	194 VIEW	Name and Address of Facility	0107	DA (to. MU	
Ba	permit. Departr Importe any inju		Voul m	Stoll. H	estion (Name of matory or other place)  Crematory  Name and Address of Facility  ARTICH MILLIE 57  527 hs (FECO RO)	ella Fui	TERAL HOINE	CITA
			28a. Part1. Enter the disease, or comp	lications that caused the death. Do not ent				Approximate
	Cate be executed /Medical Examiner bhysician and physician and street it transit transit from the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of the private of th		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	ABIAL INFARCTI			Interval Between Onset and Death
			disease or condition resulting in death)	4	7-67/10			
				Due to (or as a consequence of):	THEY DISEASE			
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	HYPERCIPID EMIA				
ó			resulting in death) Last	Due to (or as a consequence of):				
68760,	ysicia ysicia e bu	dicai		d				
	tifica ig ph as th	ledi						
Вох	or Attending Physicien fler death. Mector: After this certificin by the funeral director	Physician/Me	230. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 3 □Ectopic pregnancy			23d. Date of delivery	,
Ξ.		sicie	in the past 12 months? 1 □ Yes 2 ☑ No	4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month D	ay Year
P.0		hys	9 Unknown	9□ Unknown				
S		by F	Part II. Other significant conditions con	acco use contribute to the cause of death?				
ord			OSTEOMRIH	es 2 □ No 3 □ Probat	□ No 3 □ Probably 4 ☑ Unknown			
Records,		Completed				24a. Was ar	24b. Were autops	y findings available
Ä		mo;				autopsy perform	ned? death?	oletion of cause of □ No
Vital		Bec	25. Was case referred to medical		26. Place of Death			L NO
of V		To E	examiner?	fospital: 1 Inpatient 2 ER/Outpatien	0.1	4	nce 6 □Other (Specify)	
			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury			w injury occurred	
0		atlo	2 ☐ Accident investigation	NA	M 1 ☐ Yes 2 ☐ No			
Division		Certification:	3 Suicide 6 Could not be determined	286. Place of fillury - At nome, farm, street, factory, office 28f. Location		28f. Location (Str. City or Town	(Street and Number or Rural Route Number,	
		Ce	. NA					
	To the Hospitel within 24 hours a To the Funerel C completely filled	ledical	Z Moulta Exami	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv	occurred at the time, date and place, a	and due to the ca	use(s) and manner as stat	ed.
	the the mplet	Med		and manner stated.				
\ \	5 4 kit		29b. Signature and title of certifier  Alexander Services	1. 1.110	29c. License number  P 25010		d. Date signed (Month, Da	* '
7			7				May 16, 20	000
	m		30. Name and address of person who co		0			
			31. Date filed (Month, Day, Year)	cins Ms 583	1 Joppa Ro Su	ite 102.	Balta.M	21234
	Sta Registr		MAY 1 9 200	32 Registrar's Signature	nde			

			State of Maryland / Departm		•	ene				
		1- For State Registrar Certificate of Death Reg. No. 005 16896								
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death			
	Physicia /Medic		Edna Wilson Linth	icum		7 2005	6:50a M			
	Examin		4a. Facility Name (If not institution, give street and number) 4b. (	City, Town, or Location of Death		4c. County of Death				
			Frederick Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Frederick Inder 1 Year   If Under 24 Hrs.	8. Date of Birth	Freder 9. Birth	1CK place (State or Foreign ntry)			
	Funeral Director		212-38-2560 1 M 2 StF 99 Yrs. Morn	nths Days Hours Min.	Nov. 26,	1905 Ma	ryland			
	P .		Usual Residence of Decedent				10d. Inside City Limits			
	show	5		ı			1 ☐ Yes 2X No			
	the N	Director	Maryland Frederick Ijamsville  10e. Street and Number 10	f. Zip Code	100	g. Citizen of What Cou	ntry?			
	3e or		11392 Canary Drive	21754		United Sta	tes			
	death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was D	Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto		14. Race - Ameri Black, White,	can Indian,			
9	or Ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	es 2⊠ No <i>Specify:</i>	,,	Specify:				
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23e or 28e-f show the Medical Examirer must be cultified at	ed by	3 ☑ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's	Usual Occupation	16	6b. Kind of Business/Ir	White			
	n "na	Completed	(Specify only highest grade completed) (Give kind of	of work done during most of work. OT use retired)	ing		,			
	d with giene er the	mo.		ssing Guard		Public Sc	hools			
	be filed vital Hygie dother if	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	aiden Sumame)				
<u> </u>	ould I Men' parke		W. E. Cleveland Hyatt	Mildred I	-	C't T Ct 7:	- 0-4-1			
M M M	d 2 sh th and 7 Is n treum	1 3		dress <i>(Street and Number or Run</i> Inary Drive, Ija						
	Health tem 27 other tr		20a. Method of Disposition  20b. Place of Disposition  cametery, crematory,	(Name of	-	Dc. Location - City or T				
Ē	Pages nent of nut: If it ury or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State		21/2005 D	amascus. M	arvland			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 271s marked other then "naturel", or Iteme 23e or 28e-1 show eny Injury or other treumetic event, the Medical Examinat must be ruitified at once.	1	21. Signature of Funeral Sequice Licensee 22. Name and Address of Facility							
<u> </u>	88 2 2 8			L. Molesworth 1 Ridge Road, I						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death			
	Physician	П	Immediate Cause (Final disease or condition resulting in death)  Consestive Heart Fa	ilure						
	/Medical Examiner		Due to (or as a consequence of):							
Ů,		- e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):							
/	cuted id ansit	Examiner	that initiated events							
760,	te be executed ysician and le burial-transit		resulting in death) Last Due to (or as a consequence of):							
876	icate be executed physician and s the burial-transit	dicai	d							
89 x	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	verv			
Вох	The law requires that the death certifical to has been signed by the attending phybage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ector	pic pregnancy er (specify)		Month	Day Year			
o.	t the d by the ached	hysi	9 Unknown							
S,	w requires that been signed to should be det	by P	Tattil. Otto digital and a state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the stat				cco use contribute to the cause of death?  2 \( \sum \text{No} \) 3 \( \sum \text{Probably} \) 4 \( \mathbb{K} \)Unknown			
brd	equir sen si tould				1 L Yes	2 No 3 Pro	Dably 4 Sonknown			
Vital Records,	e law r has be je 2 sh	ompleted			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of			
al F	(0 64	O			1 □ Yes 2	XiNo 1 ☐ Yes	2 No			
<u> </u>	Physician: this certificatal director,	o Be	25. Was case referred to medical examiner?  1   Yes 2   X No							
10			27. Manner of Death 28a. Date of Injury 28b. Time of		scribe how injury occurred					
ion	Attending Ir death. ector: After	Certification:	2 Accident investigation M	Work? 1 □ Yes 2 □ No						
Division	l or Attendate after death	rtiffe	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Stree City or Town,	eet and Number or Rur State)	al Route Number,			
Ω	Hospital of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the point of the po		29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	a Hos 24 ho a Fun etely i	edical	29a. Certifier  (Check only one)  1							
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	, Day, Year)			
			mes (America M)	D 36421		May 17, 20	05			
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
	1	re.	James Amerena MD 9093 Ridgefield Drive  31. Date filed (Month, Day, Year) 32. Registrar's Signature	, # 104 Frederi	Lck, Mary	Land 21701				
Registrar MAY 1 9 2005										

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 17-2005 3:07 phan 5/3 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel North Arundel Hospital Glen Burnie If Under 1 Year If Under 24 Hrs. North Days Hours Min. 3. Date of Birth Month, Day Year July 19, 1947 9. Birthplace (State or Foreign Country) 6. Sex 1 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 57 Yrs 419-62-9573 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Funeral Director Anne Arundel Pasadena Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1217 Lorene Dr. 21122 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Ith and Mental Hygiene. 27 ia marked othar than "I r traumatic avant, "Ita Me. Elementary/Secondary (0-12) College (1-4or 5+) Planner / Estimator permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if item 27 is marked oths any injury or other traumatic avant, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William F, Brinton Leight Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Lorene Dr. Pasadena, Md. 21122 Michele L. Leight 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/20/05 Davidsonville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cem. 21. Signature of Juneral Servic Licer se 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part1. Enter the disease, or complications that decised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myccordis **Physician** mnedist /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director; 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a tel-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Cartifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

			For State Registrar	State of Man		ertificate of L			iene	15	16898
			Decedent's Name (First, Middle,			0 . 1 .		2. Date of Deat Month		Year	3. Time of Death
Н	Physicia /Medic	al	KENNETH	ALLAN	J	211		Hay	17	2005	
	Examin	er	4a. Facility Name (If not institution, g	pive street and number)  pkins Hos	pital	4b. City, Town, or	Location of Deat		4c. County		
	Funeral		1415	F	n yrs. last birthday	) If Under 1 Year	If Under 24 Hrs		Baltin	9. Birth	place (State or Foreign
	Director		303-50-9210	1XDM 2□F 5		Months Days	Hours Min.	8. Date of Birth (Month, Day, 8-9-194	Year) 7	Cou	IN
	pu »		Usual Residence of Decedent  10a, State 10b, County	10	oc. City. Town or I	ocation					10d. Inside City Limits
	Aaryla Fehov	ō	MD Anne Ar		Hanover	Location					1 ☐ Yes 2 🛣 No
	28e-	Director	10e. Street and Number		nanover	10f. Zip Code		1	0g. Citizen of \	What Cou	intry?
	h with	ai D	1739 Maco Drive			21076	,		USA	A	
	deat	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	Specify Yes or No-		e - Ameri ck, White,	can Indian,
36	or It	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 1√1√Yes 2 □ No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify		ite
Ö	ture	ed b	15. Decedent's	Year or Dates:	16a, Dec	edent's Usual Occupa	ation		16b. Kind of B		
715	nin 72 In "ne Medis	piet	(Specify only highest Elementary/Secondary (0-12)		(Giv	e kind of work done of DO NOT use retired	during most of wo	rking	custon		
21215-0036	ed with	Completed	Elementary/Secondary (0°12)	5+	Eı	ngineer			Custon	des	
nd	be file ital Hy id oth event	Be	17. Father's Name (First, Middle, La					me (First, Middle, M		10)	
<u>2</u>	hould d Men narke natic	ဥ	George Cec		19h Mai	ling Address (Street a	Verna	Mary Sh		State 7i	n Codo)
Z	nd 2 si Ith an 27 is r		Mrs. Joan Lively			Maco Dri				Jiate, 24	o code,
ē,	s 1 ar f Hea item other		20a. Method of Disposition	•	20b. Place of Disg		1		20c. Location -	City or T	own, State
E	Page nent o int: If		1 ☐ Burial 2 X Cremation 3  4 ☐ Donation 5 ☐ Other (S)	☐Removal from State cify)	•	ke Cremat:	- / 1	9/2005	Stevens	ville	e, MD
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Itame 23a or 28e-f ehoweny injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Lie	1 01	1364	22. Name and Addres	s of Facility Si	ngleton F	Funeral	Home	e P.A.
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the						001	Approximate Interval Between
11	Pnysician		Immediate Cause (Final disease or condition	. Usu	thelial	Carcin	come				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):	- Cr.					2/2
		_	Sequentially list conditions,	b. Pleasan	y al	ettueion					a weeks
1	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury								
o,	exect an and rial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):						
8760,	icate be executed physician and s the burial-transit	dical		d							
9	ding p	/Med	IF FEMALE:	23c. If yes, outcome of p	rechancy				004 B-		
Вох	leath certific attending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)				te of deliv nth	ery Day Year
0	that the de led by the a detached f	hysi	1 Yes 2 No 9 Unknown	9□ Unknown							
ď	signed to be det	by P	Part II. Other significant condition	s contributing to death but n	ot resulting in the	underlying cause give	en in Part I.	23e. Did to	oacco use cont	ribute to t	the cause of death?
ord	w require been sig should b	ted						1 □ Y€	s 2□No	3 Pro	babíy 4 Unknown
Division of Vital Records,	2 2 2	Completed				10 10		24a. Was a autops perform	ned?	Were autoprior to co death?	opsy findings available ompletion of cause of
ita	Physicien: The l this certificate ha al director, page	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only on	/		
<u>&gt;</u>	Physicien: r this certifica ral director, p	2	1 ☐ Yes 2 No	Hospitaf: Inpatient	2 ER/Outpatie		4 🗆 Nursing i	Home 5 Reside			fy)
ou c		ion:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time Injury	Work	/at <br Yes 2 □ No	28d. Describe ho	ow injury occur	red	
isi	death ctor: y the	ficat	2 Accident investiga 3 Suicide 6 Could no	t be Ose Place of Injury	- At home, farm, s		195 2 100	28f. Location (St	reet and Numb	er or Run	al Route Number,
<u>&gt;</u>	el or A	Certification:	4 Homicide determin	building, etc. (	Specify)	,,,		City or Towr	n, State)		
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of n caminer: On the basis of ex and manner stated	amination and/or	ath occurred at the tim investigation, in my op	ne, date and place pinion, death occ	e, and due to the ca urred at the time, d	ause(s) and ma ate and place,	anner as s and due t	stated. to the cause(s)
	To th within To th comp		29b. Signature and title of certifier			29c. License		2	9d. Date signe	d (Month,	Day, Year)
•			Aluthe	H.D		Kes-	000		May	//	2003
	12		30. Name and address of person with NITHA NALLU. The	no completed cause of deat ne Johns Hopkin	h (Item 23a) (Type s Hospital	a, Print) , 601, Wo	offe Storee	t, Baltim	ore, Ha	rylan	d 21287
	Sta Registr	te	31. Date filed (Month, Day, Year) MAY 1 9 2	2. Registrar's	Signature	de					

			For State		State of Ma	arylan			nt of H te of L		nd Me	-	30	'HHI	68	999
	Physici	an	1. Decedent's Name (Fi					Timou	10 01 1	Jean		2. Date of De	ath Day		3. Time	
	/Medic	al	JOAN FLAT					4h Cih	Town or	Location of I	Death	May	16	200 County of Dea		2 A M
	Examin	er	Vorth 1	Arunde l	Hospit	al		61	en B	umie.	Dealli		A	me A	runde.	)
	Funeral		5. Social Security Numb 212-32-7376	er 6. Sex		e (In yrs.	la <i>st birthd</i> ay 80 Yrs.	) If Unde Months	or 1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da 04/03/	th y, Year)		thplace (State ountry) KY	or Foreign
-	Director		Usual Residence of Dec	edent								04/03/	1925		IX I	
	/arylar	ō		o. County ANNE ARUI	NDFI.		y, Town or L N BURI								10d. Inside (	City Limits
	r 28a-	Directo	10e. Street and Number	111111 211101	TOLLI	OLL	IV DOIL		ip Code				10g. Citi	izen of What C		
	ath wit		707 DELAWA						210					USA		
5	d within 72 hours after death with the Maryland jiene. I than "natural", or Items 23a or 28a-f show The Madical Evaniner must be rodified at	by Funerai	11. Marital Status 1 □ Never Married 3 ☑ Widowed 4 □	2 Married	<ol> <li>Was Decedent I Armed Forces?</li> <li>1 ☐ Yes 2 K</li> <li>If Yes, Give</li> </ol>		.S.   13.		edent of Hi ecify Cuba 2 <b>X∷X</b> No	spanic Origir n, Mexican, f Specify:	n? (Spec Puerto F	cify Yes or No lican, etc.)	-	14. Race - Am Black, Whi Specify: W		
9500-C12	2 hour	ted b	15.	Decedent's Educ			16a. Dece	edent's Us	ual Occupa	ation			16b. Ki	nd of Business		
213	within 7 iene. than "n	Completed	Elementary/Secondar	nly highest grade y (0-12)	completed) College (1-4or 5	+)	life.	DO NOT	use retired,	luring most o ')	of workin	g	01	IN HOME		
2 0	Hyg Int,	a	12 17. Father's Name (Firs	t, Middle, Last)		-	HOM	EMAKE	K	18. Mother's	s Name	(First, Middle,		WN HOME Sumame)		
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	Physician		Immediate Cause (Fina disease or condition resulting in death)		CONG		VE	HOA	er ,	RAILU	IRE				Onset and	
	/Medical Examiner		,		Due to (or as			DRS	7 Russ	LT 101	.)					
	p #	iner	Sequentially list condition any, leading to immediate cause. Enter Underlying Cause (Disease or injur	ons, b.	Qualto (or as				7 1-016	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
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J. BOX	death e atter	Physician/Me	23b. Was decedent pre in the past 12 mon 1  Yes 2 No 9 Unknown	ths?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Feta	death 3		oregnancy specify)				2	23d. Date of de Month		Year
	that the		Part II. Other significan	t conditions con	tributing to death be	ut not res	ulting in the u	underlying	cause give	en in Part I.		23e. Did to	obacco u	se contribute to	the cause of	death?
cords	w requires been sign should be	ted by										1 🗆 1	/es 2[	□No 3□P	robably 4	Unknown
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Vital H	sician: The law certificate has b irector, page 2 s	ø	25. Was case referred t	o medical						26. Place of	f Death	1 ☐ Yes (Check only o	2 No	1 ☐ Yes	2 □ No	
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	ding P h. After t funera	tion;		Pending investigation	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	of M	28c. Injury Work 1 □ Y	at :? ∕es 2 🗀 No		3d. Describe h	ow injur	y occurred		
IVISION	or Attanter deat irector:	Certification;	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Inju- building, etc	ıry - At ho	ome, farm, st			10.110		3f. Location (S City or Tov	Street and m, State	d Number or Ri	ural Route Nur	nber,
2	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifics completely filled in by the funeral director; it	edical Ce	29a. Certifier 1 → (Check only 2	Certifying Physi	icien: To the best o	of my kno	wledge, deat	th occurred	d at the tim	e, date and p	place, ar	nd due to the	cause(s)	and manner as	s stated.	-1
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	10		30. Name and address	of person who cor	mpleted cause of de	eath (Item	23a) (Type	, Print)	44.	21111	,	Color	(00	1 16 .	MA 2	0904
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Lavouture

Zebedee Murphy 05-3394 AKG

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Depa	rtment of Health and Men tificate of Death	ntal Hygier Reg. i	ZIIID INSIII	
	Dhysisi	20	1. Decedent's Name (First, Middle, Last)		Date of Death Month	3. Time of Death	_
	Physicia /Medic		ZEBEDEE MURPHY			2005 12:50 P M	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			1631 Edmondson Avenue	Baltimore If Under 1 Year   If Under 24 Hrs.   8.	75:4	N/A	_
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 8. Age (In yrs. last birthday	Months Days Hours Min. /	Date of Birth (Month, Day, Yea 08/03/1	ar) 9. Birthplace (State or Foreign Country) 1931 NORTH CAROL	I
	and bw		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits	_
	Mary -f sh	ţō	MD N/A BALTIN	MORE CITY		1√2 Yes 2 □ No	
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?	_
	th wit		1631 EDMONDSON AVENUE	21223		USA	
	ams er n	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Warned Forces?	/as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - American Indian, Black, White, etc.	
980	be filed within 72 hours after death with the Maryland nta! Hygiene. ad othar than "natural", or Itams 23a or 28a-f show avant, Ita Madical Examiner must be chilled at	þ	1 □ Never Married 2 □ Married 3 □ Widowed 4 🛣 Divorced  1 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: US ARMY 1		,	Specify:BLACK	
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Maryland 21215-0036	d within giene. ar than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	NO NOT use retired)	SE	IIPYARD INDUSTRY	
פ	be filed v tal Hygie d othar i avant, it	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fin			
ylaı	should by and Menta markad	2	JAMES MURPHY	PENNIE	COX		
lar	s 1 and 2 should if Health and Mer itam 27 Is marks other traumatic	2		Address (Street and Number or Rural Ro			
	s 1 and if Health itam 27 othar to		ANN R. MURPHY / DAUGHTER 4014  20a. Method of Disposition 20b. Place of Dispos	MCDONOUGH RD. F			_
Jor	Pages ' nent of H int: If its iry or ot		** Commetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, cremeter, creme	atory or other place)		Location - City or Town, State	
Baltimore,	그 든 원 글		*4 □Donation 5 □Other (Specify)  21. Signature of Prineral Service Licensee 22.	FOREST 5/24/C		INGS MILLS, MD	
Ba	permi Depa Impo any ir			nowe		ERAL HOME 21207	
	Physician /Medical		23a. Party Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	on LIBERTY HEIGHT of the mode of dying, such as cardiac or res	spiratory arrest,	Approximate Interval Between Onset and Death	_
ł	Examiner		Due to (or as a consequence of):  Sequentially list conditions,  b.				
V	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
Ţ,	execul n and ial-trar	Examiner	that initiated events c				_
68760,	tificate be executed g physician and as the burial-transit	edicai	d	-			
	e as t		IF FEMALE:				
.O. Box	v requires that the death cert been signed by the attendin should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
۵.	s that ned by deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e, Did tobacco	use contribute to the cause of death?	Ī
rds	quires n sign uld be				1 🗆 Yes	2 No 3 Probably 4 Munknown	
Records,	e fav has je 2	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?	
Vital		e Co	25. Was case referred to medical		1 Yes 2□N	No 1 Yes 2□ No	
	Physician: rthis certific ral director,	To B	examiner? ***XXYes 2 No	26. Place of Death (Ch		XXOther (Specificat scene	_
on of	or Attanding Physician: after death. Diractor: Atter this certific in by the funeral director,		27. Manner of Death  Natural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at Work? 28d.	Describe how in		_
Division	Attending or death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)		Location (Street of City or Town, Sta	and Number or Rural Route Number,	_
ō	pital or ours aft aral Di illed in						_
	To tha Hospital or At within 24 hours after of the Funaral Diract completely filled in by	edicai	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death 2 Medical Exeminer: On the basis of examination and/or invitant manner stated.	occurred at the time, date and place, and o estigation, in my opinion, death occurred at	due to the cause t the time, date a	(s) and manner as stated.  nd place, and due to the cause(s)	
	Vith To t	Σ	29b. Signature and title of certifier	29c. License number  OCME		Date signed (Month, Day, Year)	
•			the lin Tolkhus		Ma	y 17, 2005	
	3		30 Name and address of person who completed cause of death (Item 23a) (Type, F	<sup>?rin</sup> l11 Penn Street B	altimore	e, Maryland 21201	
y	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 9 2005  32. Registrar's Signature				
			WILL & LUUJ Magan	AUS J			

ORIGINAL

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<u></u>		1 - State Amend Item Registrar		tema23a,2	Pagaer de Certificate of	Deathtas			5   690
Physicia	an	1. Decedent's Name (First, Middle, L	,	36			2. Date of De May 13	Pay 5	3. Time of Death
/Medic	al	Jameson  4a. Facility Name (If not institution, g	Ryan		rx	al and a decide			0400 A M
Examin	er	Anne Arundel Med			Annapol:	r Location of Deat LS	л	Anne A	
Funeral Director		5. Social Security Number 6. 214-13-2782 Usual Residence of Decedent	Sex 1 <b>X</b> M 2 □ F	ge (In yrs. last birth	Months Davs	Hours Min.	(Month, Da	th 19, Year) 8, 1986	9. Birthplace (State or Foreign Country) Washington, D
yland		10a. State 10b. County		10c. City, Town	or Location		<del></del>		10d. Inside City Limits
ith the Marylar or 28a-f show	ctor	MD Anne	Arundel	Anna	polis				1 ☐ Yes 2 X No
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
ath w	ral	760 Bon Haven D	rive		214	01		USA	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	?	13. Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☑ No		pecify Yes or No to Rican, etc.)	- 14. Race Black Specify:	- American Indian, t, White, etc. White
5-0	Completed	15. Decedent's (Specify only highest g	Education	16a. D	Decedent's Usual Occup	ation	dkina	16b. Kind of Bus	siness/Industry
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and d be fundal h	Be	James R. Reaver					e Altemo	. Maiden Surname	9)
arylan should be nd Mental marked o	2	19a. Informant's Name/Relationship		19b M	Mailing Address (Street				State Zin Code)
Ma nd 2 st lith ar 27 is r trau		George P. Mulle			0 Bon Have				
re, s 1 ar f Hea Item othe		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other place		Date		City or Town, State
Baltimore, permit. Pages 1 ar Department of Hear mportant: If Item: any Injury or other page.		1XXBurial 2 Cremation 3 14 Donation 5 Other (Spec	cify)	'	nt Mem. Gd	ns   5-1°			ville, MD
Dermi Depa Impo eny la		21. Signature of Funero Service Co.	ensee		Pardesty 12 Ridge	Funeral ly Avenue	Home, P e, Annap	.A. olis, MD	21401
Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	Chest Ir	ine.		ng, such as cardiad	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
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Division of Vital Records, for Attending Physician: The law requires tatler death.  Director: After this certificate has been signed in by the funeral director, page 2 should be on the funeral director.	Completed							rmed? pr	ere autopsy findings available for to completion of cause of path?
of Vital Physician: this certifice ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath Check onl o		2
Phys r this	5 2	1 X Yes 2 ☐ No 27. Manner of Death	1 🗀 inpati		atient 3 DOA		lome 5 Resid	dence 6 Other	(Specify)
Oivision ( or Attending I after death.  Director: After In by the funer	Certification:	1 Natural 5 Pending 2X Accident investigati 3 Suicide 6 Could not	bo = 0.5	1:50	ıry Wor	k? Yes 2 <b>X</b> ∏No	impact		do/fixed object
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To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical (	29a. Certifier 1□ Certifying F (Check only one)	hysician: To the best	of examination and/	death occurred at the tin or investigation, in my o	ne, date and place pinion, death occu	, and due to the	cause(s) and man	ner as stated.
To the within To the compli	Me	29b. Signature and attle of certifier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)
		1 ( When	UD			OCME	M	May 13, 2	2005
2					<sup>(pe, Print)</sup> 111 Pei	nn Street	t Baltin	more, Ma	ryland 21201
Star Registra		31. Date filed (Month Day, Year)	905 Registr	rar's Signature	sacto				

3327		1- State of Maryland / Department of Health and Certificate of Death	Reg. No. 2005 16902
Physi		Decedent's Name (First, Middle, Last)     WALTER JAMES MOBLEY	2. Date of Death May 13, 2005  Year  3. Time of Death 1455 P M
/Med Exam		4a. Facility Name (If not institution, give street and number)  Laurel Regional Hospital  4b. City, Town, or Location of De Laurel	Prince George's
Funera Directo		5. Social Security Number 215-36-4701 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H Months Days Hours Mi	
Maryland -f show	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location           MD         Howard         Laurel	10d. Inside City Limits 1 ☐ Yes 2 → Note
with the a or 28e	Direc	10e. Street and Number 10f. Zip Code 54 Midway Avenue 20723	10g. Citizen of What Country? U.S.A.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic avent, the Modical Examinations.	by Funeral Director	3 Widowed 4 Divorced Year or Dates:	
21215-0036 ad within 72 hours aft giene. er than "natural", or it the Modical Exami	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  Grade 8  16a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most	working   16b. Kind of Business/Industry   Apartment   Complex
Maryland 2 Id 2 should be filed Ith and Mental Hyg 7 is marked other traumatic avent,	To Be C	17. Father's Name (First, Middle, Last)	Name (First, Middle, Maiden Surmame) Elizabeth Lee
Mary of 2 sho th and h		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)
Baltimore, bermit. Pages 1 an Department of Heal mportant: If item; iny injury or other		20a. Method of Disposition  1 🛎 Jurial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Forest Oak Cemetery 5/1	Date 20c. Location - City or Town, State
Baltii permit. I Departm Importa	ouce.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s
Physicia /Medica		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Onset and Death
BOX 68760, eath certificate be executed attending physician and for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. —  Due to (or as a consequence of):  c. —  Due to (or as a consequence of):	
. 0 00	Physician/Medi		23d. Date of delivery Month Day Year
that	þ	Fait II. Dallot significant continuous contributing to document to the trooting in the didentifing section growth.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
Rec The law tte has b	Completed		24a. Was an autopsy performed?  1 less 2 \sum No 1 less 2 \sum No 1 less 2 \sum No 1 less 2 \sum No 1 less 2 \sum No 1 less 2 \sum No 1 less 2 \sum No 1 less 2 \sum No 1 less 2 \sum No 1 less 2 \sum No 1 less 2 \sum No 1 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less 2 less
on of Vital F ding Physician: Th th. After this certificate funeral director, pag	ion; To Be	examiner?  1 XYes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing	Death (Check only one)  g Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
Division  I or Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funarel Director: A completely filled in by the fu	edical C		ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s)
To th within To th	M M	29b. Signature and title of certifier  DOWNE  29c. License number  OCME	29d. Date signed (Month, Day, Year) May 14, 2005
}		MINIGIDIATIN IS. LUCESC	eet Baltimore, Maryland 21201
	State strar		

			1 - For State Registrar	State of Mar		eartment of Fertificate of		Mental Hy	giene 005	16903
	Physici /Medi	cal	Decedent's Name (First, Middle, La	Lames	Edwa	and h	lyers	2. Date of De Month	Day Year 10 200	3. Time of Death  4 pm M
	Examir Funeral Director	ier	<ol> <li>Social Security Number 6. 5</li> </ol>	nwell C	ow of ev In yrs. last birthday 92 Yrs.	Dalo	or Cocation of Dea	S. 8. Date of Bir	4c. County of Dea 140  th ay, Year)  1-1912	rthplace (State or Foreign ountry)
	he Maryland 8a-f show	ector	10a. State 10b. County	NA	Oc. City, Town or L Balto					10d. Inside City Limits 1 ▼Yes 2 □ No
	th with t	ai Dir	10e. Street and Number 2316 Ivy Avenue			10f. Zip Code 21214			10g. Citizen of What C	ountry?
9036	ours after dea ral', or Items	by Funeral Director	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No		Specify Yes or No rto Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene.  dother than "netural", or Items 23a or 28a-f show event, the Medical Examinar must be institled at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12th grade	ducation ide completed) College (1-4or 5+) 3 years	(Give	edent's Usual Occup a kind of work done DO NOT use retired Ceacher	ation during most of wo d)	orking	16b. Kind of Business Blue Print Reading	/Industry
and	be od o	Be	17. Father's Name (First, Middle, Last) Edward Franklin				18. Mother's Na Alice B		, Maiden Sumame)	
lary	2 should be and Ments Is marked sumatic or	P P	19a. Informant's Name/Relationship (	•			and Number or F	lural Route Numb	er, City or Town, State,	Zip Code)
	t and Health Sm 27 ther tr		I.illie Myers - Wi 20a. Method of Disposition		20b. Place of Disp	S Ivy Ave	- !	to, Md	21214 20c. Location - City or	Town State
Baltimore,			1 ∑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			matory or other plac Ridge Cem	1	3-2005	Balto, Md	Tom, state
Balt	permit. Page Department of Importent: If any injury or		21. Signature of Funoral Service Licer	K- Jme	)	2. Name and Addre	00 Waba		e Balto, Mo	l 21215
	Physician by Medical Examiner the prize transit the prize transit the prize transit the prize transit transit the prize transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transi	i Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a co	onsequence of):		g, such as cardia	_	rrest,	Approximate Interval Between Onset and Death
P.O. Box 6876	I the death certiti by the attending ached for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	ivery Day Year
	w requires that the been signed by th should be detache	ed by P	Part II. Other significant conditions of	entributing to death out n	ot resulting in the u	inderlying cause give	en in Part I.	23e. Did to	obacco use contribute to	/
	The law te has b	Completed by	05 W						an 24b. Were at prior to death? 1 \( \text{Yes} \)	utopsy findings available completion of cause of 2 No
Į Vi	d is	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Othe	,	ath <i>(Check only o</i> Home 5□ Resid	ine) dence 6 □Other (Spe	cify)
sion o	To the Hospitel or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely tilled in by the tuneral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 □	vat ⟨? Yes 2 □ No		now injury occurred	
Dİ	To the Hospitel or Attending within 24 hours after death. To the Funaral Diractor: Attencompletely tilled in by the tune	Certifi	4 Homicide determined	building, etc. (5	Specify)			City or Tow	,	
	ne Hospitel n 24 hours a ne Funaral I	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of m iner: On the basis of exa and manner stated	amination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	e, and due to the durred at the time, d	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2 To the complete	COLUMN TWO IS NOT THE OWNER.	29b. Signature and title of certifier	62.1	2.2	29c. License			29d. Date signed (Mont	
•			30. Name and ress if person who d	completed cause of death	(Item 23a) (Type,	Print)	27877	- / /	111ay 18	2005 vre 21239
100	Sta Registra	re.	31. Date field Month, Day, Year)  MAY 1 9 20	0, mD 32. agistrar's	560 / Signature	Lock,	Kaven	Blud	Baltim	vre 2/239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and Item 1 (243,5/20/0) IT State of Maryland / Department of Health and Mental Hygiene (1) 5

			1 - For State Registrar	State of M	aryland		artment of F rtificate of			lental H	ygiene Reg. No	000		6904
			Decedent's Name (First, Middle, La	ist)						2. Date of D	eath			3. Time of Death
	Physici		Bradley Jame	s Moore. S	Sr.					Month	Da MAY	15, 20	ar 1215	12:42FM
	/Medic Examir		4a. Fecility Name (If not institution, gir	e street and number)			4b. City, Town, o	r Locatio	n of Death			. County of E		
			Saint Joseph	Medical	Cent	er			Tows	OΠ		Be	alt:	imore
	Funeral			Sex 7. Ag 1.XX M 2.□F	ge (In yrs. la:		If Under 1 Year Months Days	If Und	er 24 Hrs. Min.	8. Date of B	irth Day, Year)	9.	Birthpla	ace (State or Foreign
	Director		213-04-2469	IMM 2UF	95	Yrs.				June 9		1	NC	
	and		Usuel Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation						10	d. Inside City Limits
	Mary	ō	MD Baltim	ore	F	reela:	nd							1 ☐ Yes 2X No
	the 28a	Pec	10e. Street and Number	-	1	I CC I a	10f. Zip Code				10g. Cit	tizen of Wha	t Count	rv?
	3a ou	O	20625 Keeney Mill	Road			21053	ì				USA		
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13.	Was Decedent of H		Origin? (Spe	city Yes or N		14. Race - A		
ထူ	or Its	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 If Yes, Give			nr Yes, specnny Cub 1 □ Yes 2X No	an, Mexic Specii		Hican, etc.)		Black, V		
Š	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "netural", or items 23a or 28a-f ehow imatic event, the Modical Examiner must be notified at	d by	3 N Widowed 4 □ Divorced	Year or Dates:			10 103 24110	- Specia	y.			Specify Wh	nite	
21215-0036	"net	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during m	ost of worki	ng	16b. K	ind of Busine	ess/Indi	ustry
2	withir ene. than	E G	Elementary/Secondary (0-12)	College (1-4or	5+)			u)			14			
מ	filled Hygi Sther	ပိ	17. Father's Name (First, Middle, Las.			FOL	eman	18. Mo	her's Name	(First, Middl		eat Pa	icki	ng
<u>a</u>	Mental arked o	To Be	James Thomas Mo	ore				10	lamie	Worsha	ım			
Maryland	2 should and Mis mar	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street					or Town, Sta	te, Zip (	Code)
	es 1 and 2 should b of Health and Ment f Item 27 is marked r other traumatic e	Μ,	Carol A. Kibler/	Daughter		2062	5 Keeney	Mi11	Road	Free1	and,	MD 21	.053	
ore C	of He of He f Item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 €	Removal from State	cer	netery, crer	sition (Name of matory or other place	ce)	May 1	ate Q	20c. L	ocation - City	or Tow	n, State
altimore,	Pages ment of ant: ff It ury or o		' 4 □ Donation 5 □ Other (Speci		Parl	kwood	Cémetery	r	2005	,	P	arkvil	le,	MD
Balt	permit. Pages Department of I Important: If It any injury or o once.		21. Signature of Funeral Service Lice	chael J. F	ין מרוי	Le	2. Name and Addre	era1	Home	of Du	lane	y Vall	ey,	Inc.
			23a. Part1. Enter the disease, or con	plications that cause	d the death.		O. W. Pado er the mode of dyin					MD 210		Approximate
	Priysician		shock, or heart failure. List only one cause on each line.  Interval Betwee Onset and De disease or condition  a. ASFIRATION FINEUMONITIS  45 MIN											
	/Medical		resulting in death)	a HDF 1 N			T I TMORIO	<u></u>					-	FI PLINE
	Examiner		Sequentially list conditions	CEREB	ROVAS	CULA	R ACCID	ENT					1	MONTH
	ם פ	iner	if any, leading to immediate cause. Enter Underlying	any, leading to immediate  Due to (or as a consequence of): ause. Disease or injury										
	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	FILE		ATION_						- 1	/EARS
60,	icate be executed physician and s the burial-transit			Due to (or as	a conseque	ince or):								
98/60	physicate sthe	dicai		_ d.			* ***						1	
×	eath certific attending p I for use as	/We	IF FEMALE:	23c. If yes, outcome	of pregnance	cv						23d. Date of	deliven	,
Rox	The law requires that the death certifi te has been signed by the attending age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4☐Pregnant a	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)	1				Month		y Day Year
o.	that the de ed by the a detached f	hys	9 ☐ Unknown	9□ Unknown										
ري ح	res that igned b	by P	Part II. Other significant conditions	contributing to death b	out not result	ing in the u	nderlying cause giv	en in Par	t I.	23e. Did	tobacco (	use contribut	e to the	cause of death?
ğ	w require been sig should b	ed t	CONGESTIVE HEART	FAILURE						1 🗀	Yes 2	□No 3□	] Proba	biy 4 Unknown
Hecords,	aw re ts bec 2 sho	Completed								24a. Wa		24b. Were	autop	sy findings available
Ĭ	sician: The law certificate has t irector, page 2 s	E								per 1 Yes	opsy formed? 2 <b>/2</b> 0 No	deat	h?	pletion of cause of No
Vital	ysician: is certifica director, p	Bec	25. Was case referred to medical examiner?			124		26. Pla	ce of Death	(Check only	-/-			
01 <	Physician: this certific ral director,	10	1 ☐ Yes 2 No	Hospital: 1 X Inpatio	ent 2 El	R/Outpatien	nt 3 DOA Oth	er: 4 🗆	Nursing Hor	me 5□Re	sidence	6 □Other (	Specify)	
	ding Phys J. After this funeral di		27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Inju (Month, Da	iry 2 iy Year) 2	8b. Time of Injury	Wor	k?		28d. Describe	how inju	ry occurred		
<u>s</u>	eath or:	cati	2 Accident investigation 3 Suicide 6 Could not 8	va -				Yes 2		206 1	(044			O M
DIVISION	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined	280. Place of in	tc. (Specify)	ie, farm, str	eet, factory, office		4		own. State		r Hurai .	Route Number,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in		29a. Certifier Certifying P	hysicien: To the best	of my knowl	edge, death	occurred at the tir	ne date	and place, a	and due to the	e cause(s)	and manne	r as sta	ted.
	24 h	edical	(Check only 2 Medicel Exe	miner: On the basis of and manner st	of examination	n and/or in	vestigation, in my o	pinion, d	eath occurre	ed at the time	, date and	place, and	due to t	he cause(s)
	To the within To the Comp	Σ	29b. Signature and title of certifier	00	^		29c. Licens	e numbe	r		29d. Da	te signed (M	onth, D	ay, Year)
			1/1/10	lly	W		D 2	047	525		2/18	0/05		
	2		30. Name and address of person who	completed cause of o	death (Item 2	23а) (Туре,	Print)	-						
			RICHARD O'MAL	LEY M.D.	7601	OSL	ER DRIV	ET	4O2WC	I MARY	YLAN:	D 212	24	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	rar's Signatu	10	anth A							
DHM	MH 17 Rev 1/2	· _	MAY 1 9 2	005	J.	Jan Barrell								

			1- State of Maryland / Dep	artment of Health and M rtificate of Death	•	giene Reg. No. 0 0 5	16905						
	ø		Decedent's Name (First, Middle, Last)		2. Date of Dea	ath	3. Time of Death						
	Physici		Ronald Wayne McGinnis		May 1	.6 Day 2005 Year	01:00A M						
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	ath						
			6409 Kriel Street	Woodlawn		Baltim	ore						
	Funeral Director		5. Social Security Number 6. Sex 1 $\times$ 7. Age (In yrs. last birthday, $\times$ 1 $\times$ 4 $\times$ 4 $\times$ 4 $\times$ 60 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birt (Month, Day August	y 17 1944 M	rthplace (State or Foreign Country) aryland						
	pu ,		Usual Residence of Decedent										
	anyla shov	<u>_</u>	10a. State				10d. Inside City Limits						
	the M	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	1 Tyes 2 No						
	with Ha or	ä	6409 Kriel Street	21207			es of America						
	Jeath	era		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto									
220	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23a or 28e-1 show other treumatic event, Ite Medical Exameratings to routilied at	by Funerai	Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates:	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2X No Specify:	Rican, etc.)	Black, Wh	,						
5	72 ho	Completed	15. Decedent's Education 16a. Dece	ident's Usual Occupation	ina	16b. Kind of Busines	s/Industry						
7	thin 7	nple	(Specify only highest grade completed) (Give life.	e kind of work done during most of work DO NOT use retired)	ing								
7	ed wi	Cou		er Installer		Roofing Co	ompany						
3	should be filed with and Mental Hygiene. Is marked other thei sumatic event, Train	Be	17. Father's Name (First, Middle, Last)			Maiden Sumame)							
) N	2 should and Men Is marke reumatic	2	Wilmer Albert McGinnis  19a. Informant's Name/Relationship (Type, Print)  19b. Maili		rgaret	Bowen	7.0.11						
2	d 2 st th and th sin treun			ing Address (Street and Number or Rura Montbel Avenue, I									
ກົ	1 an Heall tem 2				Date	20c. Location - City o							
allillo	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tree		1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  1 Baltimore-W	Washington Crem 05/	18/05	Laurel, Ma	ryland						
Ē	mit. F sartm sortar r inju			2. Name and Address of Facility Lo:									
Ŏ	Depar Depar Impor any ir		Joseph Lelper MC0333 8	3728 Liberty Road,	Randal:	lstown,Mary	yland 21133						
			23a. Paul. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between						
	Physician		Immediate Cause (Final disease or condition Probable Card	iopulmonary	embs	slus	Onset and Death						
	/Medical Examiner		4 4										
	<u> </u>	-	Sequentially list conditions,  b. Hypertensi	any, leading to immediate Due to (or as a consequence of):									
,	red	nine	cause. Enter Underlying Cause (Disease or injury	lar Accider	1								
,	icate be executed physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):	(00)									
00	ysicia ysicia	dicai	d										
0	rtifica ng ph as th		IF FEMALE:										
א מ	<ul> <li>requires that the death certific</li> <li>been signed by the attending p should be detached for use as</li> </ul>	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome or pregnancy 1 Live birth 2 Fetal death 3	⊒Ectopic pregnancy		23d. Date of de Month	Day Year						
5	the all	ysici	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)		North	Day Tour						
Ľ	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did to	obacco use contribute (	to the cause of death?						
necolus,	uires sign	Completed by	Alcoholism		1 🗆 Y	res 2□No 3₽P	robably 4 Unknown						
5	w req beer shou	iete			24a. Was	an 24b. Were a	utopsy findings available						
	The la te has age 2	duo			autop	prior to death?	completion of cause of						
N II a	en: Tifical	0	25. Was case referred to medical	26. Place of Death		2 No 1 Ye ne)	s 2□No						
	lysici iis cer direc	To B	examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatie	Othor		dence 6 □Other (Spe	ecify)						
) =	ng Ph Iter th neral		27. Manner of Death  1 ✓ Natural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  Injury	of 28c. Injury at Work?	28d. Describe h	now injury occurred							
2	tendi eath. or: A the fu	catio	2 Accident investigation	M 1 Yes 2 No									
DIVISION OF	after d Direct	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tow	Street and Number or F vn, State)	lural Route Number,						
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal and manner stated.	th occurred at the time, date and place, evestigation, in my opinion, death occurr	and due to the deed at the time, d	cause(s) and manner a date and place, and du	s stated. e to the cause(s)						
	To th withir To th comp	M	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)						
			V//Shal IND	057916		5/17/0	55						
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, F. S. Se with and Foo Geipe 31. Date filed (Month, Day, Year)  MAY 1 9 2005  MAY 1 9 2005	Print)	C 4	2 8	0007036						
	1		F. S. Sewhand 700 Geipe 31. Date (iled (Month, Day, Year) 32. Registrar's Signature	140 Ste 200	Carte	ns ville,	ILID CITTO						
	Sta Registr		MAY 1 9 2005	יי									
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			1 - For State of Maryland / Dep Registrar Ce	artment of Health and M rtificate of Death		ene 00	5 16906
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	/Medic			ormick		16 200	5 6:13 P M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of E	
			Future Care Chesapeake  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Arnold  If Under 1 Year   If Under 24 Hrs.	O Date of Birth		Arunde1
г	Funeral Director		219-22-5323 1 M 2 F 77 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Feb 5,	Year) 1928	Birthplace (State or Foreign Country) MD
	P -		Usual Residence of Decedent		100 5,	1720	1110
	arylar show	-	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	88-f	Director	MD Anne Arundel Broo				1 ☐ Yes 2 ☐ No
	a or 2		10e. Street and Number 215 West Meadow Road	10f. Zip Code	10	g. Citizen of What	•
	ns 23	eral		Was Deceded of Hispania Origina (Spe	noify Van as Na	U.S	• A •
326	be filed within 72 hours after death with the Maryland that Hygiene.  dothar than "natural", or items 23a or 28a-f show avant. The Medical Evarificat must be notified at	by Funeral	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give X  3 Widowed 4 Divorced Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)		white
Ď	natura Ical E	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16	Sb. Kind of Busine	
Maryland 21215-0036	thin 7	Completed	Elementary/Secondary (U-12)   College (1-4or 5+)	kind of work done during most of workin DO NOT use retired)	ng		1
2	ygien ygien rar th	Con	12 H	omemaker	(	Own Home	
ğ	0 7 5	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		,	
<u> </u>	2 should be and Mental Is marked o aumatic ave	<sup>2</sup>	William Leroy Derr		. Meirsch		
<u>g</u>	d 2 st th and 17 Is r traur			ng Address (Street and Number or Rura			
	1 and Health tam 27 othar tr		20a. Method of Disposition 20b. Place of Dispo	est Meadow Road, Br		MD 2122 oc. Location - City	
Ē	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)		•	
altimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic a onea.			2. Name and Address of Facility Sir	20,2005 S		
ñ	Deg		Michelle Cooney M01415	Second Avenue S.W	V., Glen	Burnie.	MD 21061
	.*		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	lar Accident	_		Of set and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	270000017			augs
	Lxammer		Sequentially list conditions, b.				
7	led nsit	Examlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	al-trar	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
Q / PC	certificate be executed ding physicien and use as the burial-transit	dical E					
Q	tificati g phy as the	ledic					
X Q	leath certific attending p	hysiclan/Me	IF FEMALE: 23b. Was decedent pregrant   23c. If yes, outcome of pregnancy   1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of	delivery
	death ne atten ed for u	sicle	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
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ecords,	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the under the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the dement of the demen	iderlying cause given in Part I.			to the cause of death?  Probably 4 Dinknown
ပ္	2 2 2	ompleted			24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
		Con			performe	d? death	es 2 No
VII	cian: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
5	Phy this ald	To .	1  Yes 2  No Hospital: 1  Inpatient 2  □ ER/Outpatien 27. Mann; of Death 28a. Date of Injury 28b. Time of			e 6 Other (S	pecify)
	ding h. After funer	Certification;	1 ✓ atural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	8d. Describe how	injury occurred	
UNISION	Atten deat ctor: y the	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home farm str		8f. Location (Stree	at and Number or	Rural Route Number,
5	al or a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after a after	erti	4 ☐ Homicide ostermined building, etc. (Specify)		City or Town, S	itate)	riarar riodio ridinger,
	To the Hospital or Attending Physician: Within 24 hours after death To the Funaral Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death 2 Medicel Exeminer: On the basis of examination and/or invanient and manner stated.	occurred at the time, date and place, ar restigation, in my opinion, death occurred	nd due to the caus d at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To th To th Compl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mo	nth, Day, Year)
	- 1		our mi	05072	5 5	5-17	-2005
	n		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) M. Mersv. U	1 - 1	1) 211	10
	Stat	te.	Standard Redinger 8601 Voterons H	1. Uersvill	0 10	1) 011	8
	Registra		31. Date filed (Month, Day, Year) O Registrar's Signature MAY 1 9 2005				

	•	1- State of Maryland / Dep	artment of Health and Mertificate of Death	lental Hygier	ZUUO IBBU/
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  DCROTHY MILLER		2. Date of Death	Day Year 3. Time of Death
Examine Funeral		4a. Facility Name (If not institution, give street and number)  Northwest Hospital Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  Randallstown  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	4c. County of Death  Baltimore  9. Birthplace (State or Foreign Country)
Director		217-24-6441 1	Months Days Hours Min.	April 10,	1927 Maryland
r 28a-f sho	Director		Owings Mills	10g.	1 ☐ Yes 2 ₺ No
ter death v Items 23s	by Funeral D	4829 Deer Park Road  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	21117  Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental hygiene. th is marked other than "naturel", or treumatic event, the Medical Event	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired) Homemaker	ng 16b.	Kind of Business/Industry  Own Home
yland hould be filed in Mental Hyge narked other satic event,	To Be C	17. Father's Name (First, Middle, Last)  Leo Fletcher Naylor	Не	(First, Middle, Maid elen Larue	Miller
ore, Mar		Leroy Dean Miller Husband 4829  20a. Method of Disposition 20b. Place of Disp		ings Mill	s, Mary land 21117  Location - City or Town, State
Baltimore, permit. Pages 1 ar Depertment of Hea Important: if item any injury or other		`4 □Donation 5 □Other (Specify) Trinity I	outh. Ch.Cem. May 1 22 Name and Address of Facility 11 ELINE FUNERAL HOME	.824 Reist	erstown Road
Cate be executed  Wedical Examiner  physicien and physicien and sthe burial-fransit	dical Examiner	23a Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Soluentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	RONIC OBSTRUCTI	22	Approximate Interval Between Onset and Death
Box 6 ath certific	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Cords, P.O. I	þ	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
al Recc	Completed			24a. Was an autopsy performed?	
Of VI	Certification: To Be	25. Was case referred to medical examiner?  1   Yes   2   X   No	of 28c. Injury at Work?  M 1 \( \text{Yes}  2 \subseteq No	ne 5 Residence 28d. Describe how in	and Number or Rural Route Number,
Division  To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the funerel	edical Cert	4 ☐ Homicide building, etc. (Specify)  29a. Certifier (Check only 2 ☐ Medicel Exeminer: On the basis of examination and/or in	th occurred at the time, date and place, a	City or Town, Sta	(s) and manner as stated.
To the Hospitel within 24 hours e To the Funerel I completely filled	Medi	29b. Signature and title of certifier  Togynon Melta M.D	29c. License number	29d. [	Date signed (Month, Day, Year)  AY 13th, 2005.
6		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) JOGINGER PR	M FITH 3M	
Stat Registra		31. Date filed (Month, Day, Year)  MAY 1 9 2005  32 Registrar's Signature	refer		

amend item#5, periff, 6844, 6/15/05 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Evelyn Iola Mann 16, May 2005 3:45P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carrol1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 5. Som 200 28 2575 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🛛 F 220-28-3585 Yrs May 19, 1927 MD Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 Oakhill Court, Apt. Al Completed by Funeral 21157 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2X No 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Whitcomb Ada Turnbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Duff Niece 2423 Erbs Drive, Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ^4 □ Donation 5 □ Other (Specify) Evergreen Mem.Gardens 5/20/05 Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Try Eline Funeral Home Tim Reisterstown, MD 21136 23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Di Inmediate Cause (Final disease or condition pper Lobe Pheumonice 2 days sease or condition esulting in death) Due to (or as a consequence of) Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1XYes 2 □ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Physician** /Medical **Examiner** tha Hospital or Attanding Physicien: The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760, Jas certificate this After death. Diractor:

burial-transit Physician/Medical the Completed Certification: within 24 hours after To the Funaral Dira 0

**Physician** 

/Medical

Examiner

Director

Be

Examiner

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Be

2

Medical

29a. Certifier

(Check only one)

**Funeral** 

Director

itam 27 is marked other than "netural", or Itams 23e or 28e-f show other traumatic avant, the Modical Ext. The results notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If itam 27 is marked other than "netural", or Ital

permit. Page Department of Important: If any injury or once. injury or

Baltimore, Maryland 21215-0036

death with the Maryland

State Registrar

31. Date filed (Month, Day, Year) MAY 1 9 2005

29b. Signature and title of certifier



Hancok Galuning ms

2911 STONER AVE

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

7/2005

2115) WESMINSTER, MARYUND

		-	For State Registrar	State of	Marylan		artment of Hortificate of L		d Men		ene g. No.		6909
	d.		1. Decedent's Name (First, Middle,	Last)						Date of Death Month	Day Ye		3. Time of Death
	Physici /Medic		JEFFREY	14	ORALI SC	0/0				AY	115/61 200		09.00 PM
	Examin		4a. Fecility Name (If not institution,	give street and nun	nber)		4b. City, Town, or	Location of De	ath		4c. County of E	Death	
			Levindale				Ba If Under 1 Year	ltimore		Date of Dieb		Dietholog	on /State or Foreign
	Funeral			i,Sex 1 2 M 2 ☐ F	7. Age (In yrs. I	last birthday) Yrs.	Months Days	Hours Mi	lin. (	Date of Birth Month, Day,	Year)	Country	
	Director		239-47-2459 Usual Residence of Decedent		53				Se	pt. I	), 1951	Mary	land
1	2 8 * <b>3</b>		10a. State 10b. County		10c. City	y, Town or Lo	ocation					10d	. Inside City Limits
	f sh	Į.	MD			Ва	altimore						1 X Yes 2 □ No
4	289	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wha	t Country	1?
1	38.0	0	2434 W Belv	edere Ave	enue			21215			U.S	S.A.	
100	ms 2	Funeral	11. Marital Status		dent Ever in U.	S. 13.	Was Decedent of His	spanic Origin?	(Specify	Yes or No- n, etc.)	14. Race - /	American White, etc	
و	or its	Ē	Never Married 2☐ Marrie	d 1 Tes If Yes, Giv	2 XNo	1	1 ☐ Yes 2 ဩ No			, ,	Specify:		
2	natural, or itama 23a or 28a-f show digal Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Da	ates:							Bla	
21215-0036	uato disa	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of v	working	1	16b. Kind of Busin	ess/indus	stry
2	hen Me	шp	Elementary/Secondary (0-12)	College (1	-4 or 5+)	me.		,			N/A		
7	be filled within 7.2 flours are loser, was the waysan be filled with the filled at seen, the Medical Examiner must be notified at event, the Medical Examiner must be notified at		-0- 17. Father's Name (First, Middle, L.	ast)		<u> </u>	None	18. Mother's N	Name (Fir	rst, Middle, M	faiden Sumame)		
and	Mental harkad of	Be C	Unknown	,					Unkn	own			
Maryland	ind Men ind Men ind marke	2	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maili	ng Address (Street a				City or Town, Sta	te, Zip C	ode)
<u> </u>	and 2 sealth ar n 27 is ner trau		Timothy Griffin	Gua	rdian	6401	York Road	d Balt	imor	e, MD	21212		
ē,	- I 6 5		20a. Method of Disposition		20b. P	Place of Disponentery, cre	osition (Name of matory or other place	9)	Date	2	20c. Location - City	y or Town	n, State
ê e	nent of nert: If it int: If it		1 ☐ Burial 2 🛣 Cremation : 4 ☐ Donation 5 ☐ Other (Sp.		State		Cremation		/18/	05 н	lampstead	, MD	)
altimore,	permit. Pag Depertment Important: I any injury o		21. Sign tuly a ral Service L	censee	,		2. Name and Addres						
m	E E E		Sans C	Mu	<u>ٽ</u>		line Fune				rstown,		
	, i		23a. Part1. Enter the disease, or shock, or heart failure. List o	emplications that c	aused the deat	h. Do not en	ter the mode of dying	g, such as card	diac or res	spiratory arre	est,	lr 1r	pproximate nterval Between
	ากงรางเลก		Immediate Cause (Final disease or condition			DU 181	U DISEAS	Z.					Inset and Death
	/Medical		resulting in death)		or as a conseq								
	Examiner		Sequentially list conditions,	b								-	
V	sit a	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseq	uence or):							
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial transit	Examiner	that initiated events resulting in death) Last	c	or as a conseq	uence of):							
760,	be eg												
687	phys phys s the	Physician/Medical		a									
Вох	certii nding use a	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			75				23d. Date o	_	
Ď į	es that the death certific igned by the attending p be detached for use as	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregn	irth 2 □ Feta ant at time of d		□Ectopic pregnancy □ Other (specify)				Month	D	ay Year
0.	by the	hys	9 Unknown	9□ Unkn					-				4.1.110
'n.	gned gned se de	by P	Part II. Dther significant condition	s contributing to de	eath but not res	ulting in the u	inderlying cause give	en in Part I.	- 1		acco use contribu		oly 4 Unknown
ord	w require been si should i								-				
Vital Records,	e law r has be je 2 sh	Completed							- 1	24a. Was ar autopsy perform	y prio	r to comp	y findings available detion of cause of
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ita ,	certificate	Be	25. Was case referred to medical examiner?	I de a citali.			0.15	26. Place of I					
of o	Physic this c	To	1 ☐ Yes 2 ☑ No			ER/Outpatie					nce 6 Other	(Specify)	
n c	Attending Physicien: r death. ector: After this certifice by the funeral director. I	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time ( Injury	Worl	Yes 2 No	200.	Describe no	w injury cocurrou		
Sic	ttend death stor:	Icat	2 Accident investig	ot be as Blace	of Injury - At h	ome farm s	reet, factory, office		281.	Location (Str	reet and Number o	or Rural F	Route Number,
É	i Ste	Certification:	4 Homicide determine	buildi	ng, etc. (Specia	(y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town	, State)		
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 12 Certifying	Physician: To the	best of my kno	owledge, dea	th occurred at the time	ne, date and pl	lace, and	due to the ca	use(s) and mann	er as stat	ed.
	P Fu	edical	(Check only 2 Medical E	xaminer: On the b and man	asis of examina ner stated.	ation and/or i	nvestigation, in my o	pinion, death o	occurred a	it the time, da	ate and place, and	due to tr	ne cause(s)
	To the To the To the Comp	Me	29b. Signature and title of certifier	۵			29c. Licens				9d. Date signed (A		
•			Livenna m	· Cuens	ly m	.0	0 03	4739		AI	A4 1776	200	5
	1		30. Name and address of person v			m 23a) (Type	, Print)		1	2221			
	,		2434 W. Belve	der Avi	eriore Sign	1500 In	more r	icing la	110	21213	G *		
	St Regist	ate	31. Date filed (Month, Day, Year) MAY 1 9 21	105	agistrar's Signi	Local	les.						
	ricgisi	. en	MAY 1 9 7	JUD STAR	ABUT JUST	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year MAY 15, 2005 **Physician** MAZEROFF 9:35 P MILDRED /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FUTURE CARE CHERRYWOOD REISTERSTOWN BALTIMORE Hours Min. 8. Date of Birth MAR. 9, 1919 5. Social Security Number If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 □ M 2 🔽 F Yrs. 86 Director 216-05-3410 MD Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2737 QUARRY HEIGHTS WAY 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (X) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE þ Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed with ment of Health and Mental Hygiene. ant: If Item 27 Is marked other thar ury or other traumatic event, the M SALESWOMAN DEPARTMENT STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SCHNEIDERMAN ပ LOUIS EDITH ALEXANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL GOLDEN DAVIS / DAUGHTER 2737 QUARRY HEIGHTS WAY - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or RIGA KURLANDER VEREIN 05/18/2005 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE, MD 21. Supriur Funeral Service Locensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one acuse on each line. 23a. Part1. Enter the disease, shock, or heart failure. L Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) Physician alleson /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 Yes 2 No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attanding 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral ( 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of c

Registrar

State

30. Name and address

31. Date filed (Month, Day, Year)

Illen

MAY 1 9 2005

rea

cause of death (Item 23a) (Type, Print)

ltteman

22. Registrar's Signature

			1- State of Maryland / Department	artment of Health and Me rtificate of Death		en <b>e</b> 0 0 5	16911
	Physici	20	1. Decedent's Name (First, Middle, Last)		Date of Death     Month		3. Time of Death
	/Medic		LOLA VERNA MILLNER		MAY 1	6 2005	8:20 P <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give street and number) 3413 W. FRANKLIN STREET	4b. City, Town, or Location of Death		4c. County of Dea	th
	Francis		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	BALTIMORE CIT	Y 8. Date of Birth	N/A	hplace (State or Foreign
	Funeral Director		225-01-1299 1 M 2 F 95 Yrs.	Months Days Hours Min.	(Month, Day, 1	Year) Co	CTH_CAROLII
	p .		Usual Residence of Decedent			909 NOF	
	within 72 hours after death with the Maryland ane. than "neturel", or items 23a or 28e-1 show ha Nedical Examinar must be notified at	2		ALTIMORE CITY			10d. Inside City Limits 1
	the M	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	
	Mith ME or	2	3413 W. FRANKLIN STREET	21229	100	USA	ountry ?
	death ms 2;	Funeral		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - Ame	nican Indian,
و	after or ite		1 Never Married 2 Married 1 Yes 27 No		lican, etc.)	Black, Whit	
5-0036	rours	d by	3X Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes XX No Specify:		Specify:	BLACK
7	"net	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	g 16	6b. Kind of Business	Industry
12	withi iene. than	дшо	Elementary/Secondary (0-12) College (1-4or 5+) 12TH	LABORER		MILL FAC	TORY.
ğ	I Hygie other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name			
<u>Ja</u>	should be nd Mental marked o	To B	EPHRAIM MITCHELL	THELMA	WILS	ON	
Maryland	C1 60 50 50		19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number or Rural			
	1 and 1 Health em 27 other tr				-		MD 21229
altimore,			AZPORIAL 2 Cremation 3 Decinoval from State	natory or other place)		oc. Location - City or	
	it. Pa intmen intant: njury		(1,200)	MEM. PARK 5/21		BALTIMOR	- ·
Ba	permit. Page Department Important: If any injury or once.		1 War O. Jour 4	2. Name and Address of Facility HOV	GHTS AV	E., BALT	TIMORE, MD
	Fnysician /Medical Examiner		23a. Plant office the disease, or complications that caused the death. Do not ent shock, or leart fature. List only one cause on each line.  Immediat cause (Pinal disease in condition resulting in death)  Due to one signonsequence of:  Sequentially list conditions,	er the mode of dying, such as cardiac or 919 500 'S Clu			Approximate Interval Between Onset and Darth
28760,	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				0
.O. Box (	that the death certifined by the attending detached for use as	Physiclan/Me		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
ecords, P	Se Jo	by	Part II. Other significant conditions contributing to death but not resulting in the up	nderlying cause given in Part I.		cco use contribute to	
eco	law requir las been si s 2 should I	Completed			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
T E		Con			performe	d? death? No 1 ☐ Yes	20 46
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death /			
on of	ding Phys h. After this funeral di	tlon; To	27. Manner of Death  Landaural 5 Pending  28a. Date of Injury (Month, Day Year)  Injury  28b. Time of Injury	TO DOA 4 I Harsing Horis	e 5 Residence 3d. Describe how	ce 6 Other (Specinjury occurred	cify)
DIVISION	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)		Bf. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number.
	ne Hospit n 24 hours ne Funere	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invand manner stated.	n occurred at the time, date and place, an vestigation, in my opinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
)	To the Youthin To the Comple	¥	29b. Signature and title of certifier	29c. License number	290	Date signed (Month	Day, Year)
	1		30. Name and address of person who completed cause of geath (Item 23a) (Type.	Print) VUUDZOY	1 6	0/18/0	W S
	2		Leslie S Robinsmi	MD 295 Pacas	t bul	lemne	1 2/201
	Sta Registra		31. Date filed (Month, Day, Year)  MAY 1 9 2005  MAY 1 9 2005	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	,		, , ,

			For State Registrar	State of Ma	aryland / Dep	artment of F ertificate of			6000	16912
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	Physici	an						Month	Day Year	- 32m M
	/Medic	al .	Helen (nmn) (			Ab City Town o	r Location of Death	MA7	4c. County of Deat	J 777
4	Examin	er	4a. Facility Name (If not institution, gi		0 / 1.	40. Oily, rowin, o	Location of Death		4100	 Care-1
				Sex 7. Ag	le (In yrs. last birthday	It Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9. Birt	hplace (State or Foreign
	Funeral			1 M 2 X F	Van	Months Days	Hours Min.	8. Date of Birth (Month, Day,	1921 Pen	nsvlvania
	Director		182-16-3087 Usual Residence of Decedent		83 Trs.			Aug. 8,	1921   Fell	IISy I Valida
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Man	ţō	Maryland Harfo	ord	Bel A	ir				1 ☐ Yes 2X No
	r 28e	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	3e o	0	125 Fairmont Di	rive		210	14		USA	
	Itams 2	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Btack, White	
9	or Ita	Ē	1 Never Married 2 Married			1 ☐ Yes 2€ No		rilozii, oto.)	Specify:	0, 010.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or llams 23e or 28e-f show the Medical Evantinat most be rediffed at	by	3 Vidowed 4 □ Divorced	Year or Dates:		12 103 22 110			Specily.	White
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21	ifhin Ban.	n jd	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retire	d)			
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pu	be fill tal H d oth	Be	17. Father's Name (First, Middle, Las	alamar						
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If it itam 27 is marked other than "natural", or Itams 23e or 28e-f show or other traumatic avant, Itam Medical Exaction man be redified at	10			1		L		<u> </u>	Ti- Code)
<u>la</u>	2 sh and is m		19a. Informant's Name/Relationship						City or Town, State, 2	
	1 and 2 Health Iam 27	}	Margaret Anne Ro	ohrbaugh/ I	Daughtter 1				. Marylan Oc. Location - City or	
9	Pages 1 nent of F int: If its iry or ot		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3	Removal from State	cemetery, cre	ematory or other pla	ce)			
Ë	Pa Pa		*4 □ Donation 5 □ Other (Spec			oft Cemete			Linwood, P.	A
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.		21. Signature di Funeral Service Lic	ensee	1	McComas 1	ess of Facility Funeral Ho	ome, P.A.		
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. Box 68760,	death certificate be executed  e attending physician and  mod for use as the burial-transit	icai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence of):  a consequence of):  of pregnancy 2 ☐ Fetal death 3	□Ectopic pregnanc				*
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DHMH 17 Rev 1/2001

Helen P. OCONNOR

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

	1 For State Registrar		partment of Health and Nertificate of Death	•	ne 0.05	16914
	1. Decedent's Name (First, Middle, Last,			2. Date of Death		3. Time of Death
Physician /Medica		ak		Month May	11 2005	0300 A M
Examine	A PR. Int. As and a second	street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Upper Chesapeake	Medical Center	Bel Air		Harfor	đ
Funeral Director	5. Social Security Number 218-38-3947    Usual Residence of Decedent	7. Age ( <i>In yrs. last birthda</i> , M 2 F 63 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye May 9, 19		nplace (State or Foreign untry) yland
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ygiene. ser than "nature t, the Medical E	15. Decedent (Specify only highest Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	orking	16b. Kind of E		,
even Be	17. Father's Name (First, Middle, L	7	Elec	tronic En	18. Mother's Na	me (First, Middle, N			ntracto
and and sand	19a. Informant's Name/Relationsh Terry Ream (So	ip (Type, Print)				ural Route Number,			Code)
nt: If	20a. Method of Disposition  1 🛣 Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp	3 Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place Veterans	ce)		20c. Location	- City or Tov	
Departmen Important: any injury once.	21. Signature of Funeral Service C	• •		2. Name and Addres Hardesty	ss of Facility Funeral	Home, P.A	Crowns		
iysician Medical	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. Cov	line.	er the mode of dyin	g, such as cardia	c or respiratory arre	st,		Approximate Interval Betwee Onset and Dea
xaminer	Sequentially list conditions	b. Due to (or a	s a consequence of):	ny dise Jewlan renal	dina	u.			Zyrs
physician and is the burial-transit		c	s a consequence of):	renal	dina.	u			Zys
physicials the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the burners the bur		d. En	cephelog	rathy					2 dan
te has been signed by the attending page 2 should be detached for use a completed by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)				te of delivery	∕ ∂ay Year
s been signed be set a should be deta	Part II. Other significant condition	s contributing to death	but not resulting in the u	nderlying cause give	en in Part I.				cause of death
ste has page 2						24a. Was an autopsy perform	ed?	prior to comp death?	sy findings avai pletion of cause
is certificate director, pag To Be Co	examiner? 1 □ Yes 2 <b>X</b> No	Hospital: 1 Minpati	ent 2 ER/Outpatien	t 3 DOA Othe		ath (Check only one		or (Specific)	
within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to ompletely filled in by the funeral director. To Be C Medical Certification; To Be C		28a. Date of Inju (Month, Da	ury 28b. Time of	28c. Injury Work		Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			
within 24 hours after d To the Funeral Direct completely filled in by 1 Medical Certific		building, e	jury - At home, farm, stre tc. (Specify)			28f. Location (Stre City or Town,	State)		
in 24 hou he Fune pletely fill edical		Physician: To the best xaminer: On the basis of and manner st	of my knowledge, death of examination and/or inv ated.	occurred at the tim restigation, in my op	e, date and place inion, death occu	, and due to the cau rred at the time, dat	ise(s) and ma e and place, a	nner as stat and due to th	ed. ne cause(s)
d S m S	29b. Signature and title of certifier	1	mdSTAn death (Item 23a) (Type, I 094 Edmy ar's Signature	29c. License	number	290	d. Date signed	Month, Da	ıy, Year)
(	1 W V V . /	Y	mazran	7003	6450	Ma	my 11	, 200	9 <del>5</del>

			1- State of Maryland / Department of Healt Certificate of Dea		ntal Hygie	4000	16916
			1. Decedent's Name (First, Middle, Last)		. Date of Death		3. Time of Death
	hysici /Media		Margaret Beatrice Ross	Ma	ay 16, 2	Day Year	10:30 A <sup>M</sup>
	xamir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location			4c. County of Deat	
				de Grace		Harfo	ord
	neral ector		1 M 2 Str	urs Min.	Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign untry)
			219-10-1626 90 Tis.  Usual Residence of Decedent	De	ec. 8, 1	.914   N	Maryland
ırylan	H	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Me Ma	100	Director	Maryland Harford Havre de Grace				1 Tes 3 No
with th	TE D	Dire	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Co	untry?
death with the Maryland	Filliand	Funerai	716 Country Club Road 21078  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	ic Origin? (Specif	y Voc or No	USA 14. Race - Ame	riogo Indian
offer d	i a	Fun	Armed Forces? If Yes, specify Cuban, Mex  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No		an, etc.)	Black, White	
OU36 hours after ural or Its	1	l by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	ecify:		Specify:	White
Z15-0036 thin 72 hours af e.	tre Modical Exaction roust be retified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during r	most of working	16b	. Kind of Business/	
within 72 ane.	N S	mpi	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)				
E H	T,	ပိ	3 Registered Nurse 17. Father's Name (First, Middle, Last) 18. M.	SE Mother's Name (F	First Middle Mai	Health C	are
_ ~ ~ ~	100	To Be		da Alic		,	
ک و ځو	umat	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Num				ip Code)
2 o 5 b	. =		Patricia A. Wood / Daughter 298 Winners Circ	cle Driv	re, Red :	Lion, PA	17356
Ore, les tar of Hea	or other traumatic		20a. Method of Disposition  1 □ ❸ urial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		. Location - City or	
altimor mit. Pages partment of I	jury		Bel Air Memorial Gard	dens 5-1	9-05	Bel Air.	Maryland
<b>Baltimore,</b> permit. Pages 1 an Department of Heal	any in		21. Signature for Funeral Service Licensee 22. Name and Address of Fa	ral Home	P.A.	1/2	70.
	- W C4		Michael Language 131/ Cokesbur	ry Road,	Abinada	on, MD 21	
			23a. Part1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such shock, or fleart failure. List only one cause on each line.	h as cardiac or re	spiratory arrest,		Approximate Interval Between Anset and Death
Physi /Med			disease or condition resulting in death)	cece of	eleni		3 CLOUS
Exam			Due to (or as a consequence of):				V
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
A SE	ransit	Examiner	that initiated events				
ate be execut	urial-t		resulting in death) Last  Due to (or as a consequence of):				
The Cord das, F.O. BOX 08/00, The law requires that the death certificate be executed the has been signed by the attending physician and	the burial-transit	dicai	d				
OX O OX O OX O OX OX OX OX OX OX OX OX OX OX OX OX OX OX OX OX OX OX O	for use as	- ου ⊢	IF FEMALE: 23c. If yes, outcome of pregnancy				
eath c	lor u	hysician/M	in the past 12 months?			23d. Date of delin	/ery Day Year
the d	detached	ysi	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown				
s that	d be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	Part I.	23e. Did tobacc	o use contribute to	the cause of death?
quire on sig	should b				1 ☐ Yes	2 <b>1</b> No 3 □ Pro	bably 4 Unknown
law requires t	N	Completed			24a. Was an		opsy findings available
	Irector, page 2 s	E .			autopsy performed	? death?	ompletion of cause of
cian:	actor,	Be (	BARTINIBL?	Place of Death C			
Physi this c	al dire	2		Nursing Home		6 ☐ Other (Spec	ify)
ding After	funer	ion	27. Manner of Death  1		. Describe how in	njury occurred	
Attending r death.	y the	ficat	3 Suicide 6 Could not be 28e Place of Injury - At home farm street factory office		Location (Street	and Number or Rui	al Route Number
after Dira	d in b	Certification:	4 Homicide determined determined building, etc. (Specify)	201.	City or Town, St		ai noule ivuilibei,
oscita hours inera	ytlle		29a. Certifier  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (Chark only  (C	e and place, and	due to the cause	(s) and manner as	stated.
DIVISION OF VICE To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certifica	completely tilled in by the funeral director, page	edica	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, one)	death occurred a	at the time, date a	and place, and due	to the cause(s)
To t withi	СОШ		29b. Signature and title of certifier 29c. License number		29d. I	Date signed (Month,	Day, Year)
			16 han MD 1326		5	16/07	
	3		30. Name and address of person who completed cause of death (Item 23a (Type, Print)	ann D	Gran	MOZI	078
Re	Sta egistra		31. Date filed (Month, Day, Year) MAY 1 9 2005  Registrar's Signature	1			

			1 - For State Registrar	te of Maryland / Depa Ce	artment of Health and rtificate of Death		ene 0 0 5 3. No.	16917
I	Physici		Decedent's Name (First, Middle, Last)  AARON		ROSENSTEIN	2. Date of Death Month MAY 1	Day 2005	3. Time of Death 8:08 A M
	/Medic Examir		4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or Location of Dea		4c. County of Death	0.00 A
			CATERED LIVING OF PI		BALTIMORE		N/A	
	Funeral Director		5. Social Security Number 6. Sex 11 M 2 I	7. Age (In yrs. last birthday)  101 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir		(ear) 9. Birth Coul	place (State or Foreign ntry) MD
	yland how		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	8a-f s	ctor	MD N/A	BALT	IMORE			1 Yes 2 □ No
	with the	Funeral Director	10e. Street and Number 7218 PARK HEIGHTS A	VENUE #116	10f. Zip Code	100	g. Citizen of What Cou	*
	death ms 23	era	11. Marital Status 12. Was	Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Americ	USA can Indian.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evanither must be rediffed at once.	by	1 ☐ Never Married 2 ☐ Married 1 ☐	Yes 2 X No	lf Yes, specify Cuban, Mexican, Puè 1 □ Yes 21 <mark>X</mark> No <i>Specify:</i>	rto Rican, etc.)	Black, White, Specify:	
5-0	72 hc "natur dicel	eted	15. Decedent's Education (Specify only highest grade compl	eted) (Give	dent's Usual Occupation kind of work done during most of wo	orking 16	6b. Kind of Business/In	dustry
21215-0036	ed within ygiene. ner than '	Completed	5+	ege (1-4or 5+)	MACIST	F	PHARMACY	<u>-</u>
Maryland	ould be fii Mental H arked otl	To Be	17. Father's Name (First, Middle, Last) USHER	ROSE	INSTEIN BERTHA	me (First, Middle, Ma	uiden Sumame)	MANNES
Mar	12 sho h and 7 Is ma traum		19a. Informant's Name/Relationship (Type, Print		ng Address (Street and Number or F			
	Healt Healt tem 2		20a. Method of Disposition	20b. Place of Dispo	GLENWICK COURT sition (Name of		CE, MD 2120 c. Location - City or To	
altimore,	Pages nent of I ant: If its ary or o		1 X Burial 2 □ Cremation 3 □ Removal  4 □ Donation 5 □ Other (Specify)	Hulli State	natory or other place) [IENDSHIP CEM 05/		BALTIMORE,	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee				N & BROS.,	
	<u>.</u>		23a. Part1. Enter the disease, or complications	that coursed the death. Do not only	900 REISTERSTOWN	ROAD - PI	KESVILLE,	
	Physician		shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	1894 FAHM			Approximate Interval Between Onset and Death
	/Medical Examiner		Di	ue to (or as a consequence of):				
		ner	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequence of):				
	icate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last					
8760,	s be ex			ue to (or as a consequence of):				
9	tificate ig phys as the	ledical	d.		-			
Вох	eath certifi attending for use as	Physician/M	in the past 12 months?		Ectopic pregnancy		23d. Date of delive	ery Day Year
o	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐	Pregnant at time of death 5 Unknown	Other (specify)		, , , , , , , , , , , , , , , , , , ,	Day Four
Division of Vital Records, P.	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing	to death but not resulting in the ur	nderlying cause given in Part I.		cco use contribute to the	ne cause of death?
000	s been si	olete				24a. Was an	24b. Were auto	psy findings available
al Re	sician: The lav certificate has rector, page 2.	e Completed	25. Was case referred to medical			autopsy performe 1 ☐ Yes 2 🔀	d? prior to cor death?	npletion of cause of
$\leq$	Physician: this certific al director,	OB	examiner?  1 Yes 2 No Hospital:	1   Inpatient 2   ER/Outpatient	Other	ath <i>Check only one)</i> Home 5 ☐ Residence	e 6 <b>Æ</b> Other (Specify	ASSUTED
o uo	Hospital or Attending Physician:     24 hours after death.     Funeral Director: After this certifice telly filled in by the funeral director.	atlon; T		Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how		" CINNC
DIVIS	al or Attend after death Director: d in by the f	Certification;	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, stre building, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	e Hospita 24 hours e Funera letely fille	edical	Check only 2 Medical Examiner: On	o the best of my knowledge, death the basis of examination and/or inv manner stated.	occurred at the time, date and place estigation, in my opinion, death occi	e, and due to the caus urred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of certifier		29c. License number	29d.	. Date signed (Month, I	Day, Year)
14.7	~	-	MIUM	Jm	P0847625		5/17/05	
1	SI		30. Name and address of person who completed	se of death (Item 23a) (Type, I	or Drive, Suit	= 311 +	กพ (ทพ. พก	21204
1	Stat	ė	31. Date filed (Month, Day, Year)	32. Registrar's Signature	representation	· / II · · · · · ·	المالم والمديم الم	-1- 1
	Registra		MAY 1 9 2005 A	See A Rosell				

Jessica	Senior.	For State

pena	State of Maryland / Department of Health and Mental H	lygie

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100	13	-	1 /
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ssica Seni	or	Registrar		artment of F			iene 0 (	5 16918
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last)  Jessica Leigh Senior  4a. Facility Name (If not institution, give street and number)			or Location of Death	2. Date of Deal Month May	17, 2 4c. County	
Funeral Director	ľ	117-70-2434 1□M 2XF 30	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Ofton If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 20,		Arundel  9. Birthplace (State or Foreign Country) Maryland
rith the Maryland or 28e-f show	Director	Usual Residence of Decedent           10a. State         10b. County         10           Maryland         Anne Arundel           10e. Street and Number	c. City, Town or Lo	ofton  10f. Zip Code		1	0g. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2 🛣 No //hat Country?
er death w Items 23a Der must	by Funeral D	2463 Wentworth Drive  11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Every Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:			1114 dispanic Origin? (Spe an, Mexican, Puerto I Specify:			- American Indian, k, White, etc.
Maryland 21215-0036 d.2 should be filed within 72 hours alt th and Mental Hygiene. It is marked other than "netural", or treumetic event, the Medical Exert	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  4  17. Father's Name (First, Middle, Last)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired Vestigate	during most of workird)	ng .		siness/Industry Investigative Services
Maryland and 2 should be leath and Mental m 27 is marked o	To Be	James Coles Senior  19a. Informant's Name/Relationship (Type, Print)  James & Deborah Senior/Parent	3552	rth Higg	18. Mother's Name  Debora  and Number or Rura  ins Street	h   Route Number   Terry	Krampit City or Town, S ville	z
Baltimore, permit. Pages 1 ar Department of Hea Importent: If Item; any injury or other once.		1 \Burial 2 \Cremation 3 \Removal from State 4 \Donation 5 \Dotter (Specify)  21. Signat re f Funeral Service Licensee	Hillside	cemeter)	ce)	2005	Terryvi	lle, CT
Physician /Medical Examiner		23a. Parti Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Asphyxical Due to (or as a condition or condition resulting in death)	100957 1 1 death. Do not enter	411 Annap or the mode of dyin	oolis Road	Odentor respiratory arre	n, Mary	1and 21113  Approximate Interval Between Onset and Death
ds, P.O. Box 68760, uires that the death certificate be executed signed by the attending physician and deetached for use as the burial-transit dise detached for use as the burial-transit.	edical Examiner	Sequentially list conditions, it is to be cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a co						
ds, P.O. Box 68760, irres that the death certificate be ex signed by the attending physician is be detached for use as the burial	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 X Unknown  23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day Year
ds, Puires that signed to be dett	d by P	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part I.			bute to the cause of death?

To the Hospitel or Attending Physician: The law requivithin 24 hours after death.

To the Funerel Director: After this certificate has been completely filled in by the funeral director, page 2 should

Be Complete

Certification: To

Medical

Division of Vital Recor

24a. Was an autopsy performed? 1 Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

2 No 1 Yes

25. Was case referred to medical examiner? 1XX es 2 □ No 27. Manner of Death

1 Natural

2 Accident

3XXSuicide

FndMonth, Day Year)
5-17-05 5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 28h. Time of 9:25 A

28c. Injury at Work?

Cther. 4 Nursing Home 5 Residence 6 XOther (Specify) SCENE

Injury at Work?

1 Yes 2 XNo Placed plastic bag over head and took pils.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **found at home** 

28f. Location (Street and Number of Rural Route Number, City or Town, State) 2463 Wentworth Dr Crofton Maryland

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

eenhere MD

**OCME** 

May 18, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore Maryland 21201

State Registrar

MAY 1 9 2005

31. Date filed (Month, Day, Year)

			Please					f Health and I	-		
			For State	State of	iviai ylai i		tificate c			g. No. 0 0 5	6919
т			Registrar  1. Decedent's Name (First, Middle, Las	st)			timodio o	7 0000	2. Oate of Death	i	3. Time of Death
	Physicia			Luther	Frank1	in Sta	aub		Month May	Day Year	005 1435 M
	/Medic Examin		4a. Facility Name (If not institution, give	street and num	iber)		4b. City, Town	n, or Location of Death	1	4c. County of D	eath
			Shady Grove Adver					ockville_		<del></del>	gomery
П	Funeral		Social Security Number     6. S     1	ex ⊠M 2□F	7. Age (In yrs. I	last birthday) Yrs.	Months Da	ear If Under 24 Hrs. ys Hours Min.	(Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		214-28-7507 Usual Residence of Decedent		89				Dec. 1,	1915	Maryland
	yland		10a. State 10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits
:	a-fst	ctor	Maryland Montgo	omery	Gern	nantown	1				1 ☐ Yes 2 🔀 No
	or 28	Directo	10e. Street and Number				10f. Zip Cod		10	g. Citizen of What	Country?
	within 72 hours after death with the Maryland jiene. Then "natural", or Items 23e or 28e-1 show Ite Medical Exactinal proteit by neitified at	rail	23212 Ridge Road	1 10 111 - 0		0 10		20876		United S	tates
	ter de Items	Funerai	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Dece Armed For 1  Yes	ces?	S. 13.	f Yes, specify C	of Hispanic Origin? (S Cuban, Mexican, Puert	o Rican, etc.)	Black, W	
50 00 00 00 00 00 00 00 00 00 00 00 00 0	urs af	ρχ	3 ⅓Widowed 4 □ Divorced	If Yes, Give Year or Da	9		1∐Yes 2⊠I	No Specify:		Specify:	nite
2-003p	72 ho	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Usual Oc	cupation	rking	6b. Kind of Busine	ss/Industry
7	within ene. then "I	npie	Elementary/Secondary (0-12)	College (1-	-4or 5+)			one during most of wor tired)		-	
N.	filed w Hygier thar th		7 17. Father's Name (First, Middle, Last,	1			Security		ne (First, Middle, M	Secur	ity
Ē	e d a d a d a d a d a d	Be	Luther James Star					Sarah E.		and of the state of	
2	should be ind Menta i markad umatic ev	မှ	19a, Informant's Name/Relationship (			19b. Mailii	ng Address (Str	eet and Number or Ru		City or Town, Stat	e, Zip Code)
Ž	s 1 and 2 should f Health and Mer itam 27 is marks othar traumatic		Barbara Staub/ Da			23212	2 Ridge	Road, Dam	ascus, Ma	ryland 2	0872
ē.	# O		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name or natory or other	place)	Date 2	Oc. Location - City	or Town, State
altimore,	Pages nent of ant: If it any or o		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif		state			1 Park 5/2	0/2005 F	Rockville	, Maryland
<u>a</u>	permit. Page Department of Important: If any Injury or once.		21. Signature of Smeral Service Licer	1500	. 1	024	Name and Ad	dress of Facility Molesworth	P. A. Fu	neral Ho	me
<u>n</u>	40 F # 9		Jode the	Myw		20	5401 Ri	dge Road,	Damascus,	Marylan	d 20872
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	one cause on ea	aused the deat ach line.	h. Do not en	er the mode of	dying, such as cardiad	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a/3	CUTE		CARD	ise IN	FRACTE	·~	Hones
	/Medical Examiner				or as a conseq	_	11-11				V.50 0 6
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	or as a conseq		MELL	TUP			+ CF//CS
/	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c /	ORON	(sn	ART	car nir	ENSE		YEARS
60,	be executed sician and burial-transit		resulting in death) Last	Due to (	or as a conseq	uence of):					
-	ate 5/2 Sch	lical	•	d							
x 68	eath certificat attending phy for use as th	Physician/Medi	IF FEMALE:	23c. If yes, out	come of preon:	ancy				22d Data of	dolivon
Вох	ath utter for u	ian	23b. Was decedent pregnant in the past 12 months?	1□Live bi	irth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pregna			23d. Date of Month	Day Year
О	0 0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkno				·			
	The law requires that the de ite has been signed by the a page 2 should be detached i	by Pt	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying cause	given in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
rds	w require: been sig should b		CONGETTIV	TO PEN	2125 1	Jiva,	15		1 □ Ye	s 2□No 3□	Probably 4 Monknown
Vital Records,	law re as bee 2 sho	Completed	DEMERTI	2					24a. Was ar	24b. Were	a autopsy findings available to completion of cause of
		Mo							perform 1 ☐ Yes 2	ned? deatl	res 2 No
/ita	nyaician: Th sis certificate director, pag	Be (	25. Was case referred to medical examiner?	I I a a - it a la					ath (Check only one	9)	
	Phyai this c al dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1 4	npatient 2	ER/Outpatie		Other: 4 Nursing F	dome 5 ☐ Reside		Specify)
Division of	ding h. After funer	tion	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation	(Mont	h, Day Year)	Injury		Work? 1 ☐ Yes 2 ☐ No	200. 50001150 110	William Coosti Ga	
18	after deatl	fical	3 ☐ Suicide 6 ☐ Could not b	28e. Place	of Injury - At h	ome, farm, st	reet, factory, off		28f. Location (Str	reet and Number o	r Rural Route Number,
	D in the	Certification:	4 Homicide	buildii	ng, etc. <i>(Specil</i>	(y)			City or Town	, State)	
	To the Hospital within 24 hours a To the Funeral C completely filled it		29a. Certifier 1 Certifying P	hysician To the	best of my kno	owledge, dear	th occurred at the	ne time, date and place my opinion, death occi	e, and due to the ca	use(s) and manne	r as stated.
	To tha H within 24 To tha F complete	ledicai	one)	and man	ner stated.	11077 1170 01 11	-				
	With To Con	Σ	29b. Signature and title of certifier	/~ /	n.o.			cense number		ed. Date signed (M	anth, Day, Year)
)	E				on of death the	m 22c\ (T =					/
	[A]		30. Name and address of person who		or death (Iter	1 23a) (Type)	( GROVE	2 ADVENTA	IT HOIS	1502	ROCKVINE, M.
	Site	ate	31. Date filed (Month, Day, Year)		istrar's Signa	ature	4				
	Regist		MAY 1 9 2	2005	distrar's Signa	A. A	bert				

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Ann L. Schlee May 16 2005 7:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10516 Howard Ave. Cockeysville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec. 1, 19 Birthplace (State or Foreign Country)

VA 6 Sex **Funeral** Days Hours 1 □ M 2 □ F 217-16-1459 Yrs Director 81 Dec. 1923 Usual Residence of Decedent 10a, State Show 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinan must be notified at Director 1 ☐ Yes 2 ☐ No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10516 Howard Ave. 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) C/P Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Supervisor Phone Communication should be filed vand Mental Hygies marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Norman W. Keay ೭ Annie M. Walker and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 st Department of Heelth and Important: If item 27 is n eny injury or other treun Francis Keay/brother 11913 Manor Rd,, Glen Arm, MD 21057 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Moreland Memorial Park 5/21/05 Parkville, MD 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Michael Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 flagle 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FAILURE RENAL disease or condition months resulting in death) /Medical Due to (or as a consequence of): Examiner ANEMIA 3 years Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be Physician/Medical as attending p Box IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 \(\subseteq\text{ Yes}\) 2 \(\subseteq\text{ No}\) 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) P.O. | signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, BLADDER CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔊 Unknown peeu Hypertusion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 1 Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 52 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural Injury safter death.
I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 150232 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Cyrus Hamidi, M.D. 1 North Park Dr., Suite 201, Hunt Valley, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 1 9 2005

			For State	State of M	laryland	•	artment of F		d Mental Hy	Em	005	16921
			Registrar  1. Decedent's Name (First, Mi	iddle, Last)			Timeate of	Doutin	2. Date of De	Reg. No.		3. Time of Death
	Physici		WILLIF	M STA	REE	Y			Month	Day		5 1.24 P.M
	/Medic Examir		4a. Facility Name (If not institu				4b. City, Town, o	r Location of De	1 (1)	- (	County of Deat	
			(GOOD SAI	MARITAN A	tosP1	746	131	ALTIM	ORG		N/	A
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. la		If Under 1 Year Months Days	If Under 24 H	frs. 8. Date of Bi (Month, Di July	rth ay, Year)	9. Birtl	nplace (State or Foreign untry)
	Director		199-03-3485		86	Yrs.			July	4 19	18 N	1D
	and and		Usual Residence of Decedent 10a. State 10b. Cou		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Many fed a	tor	MD Ba	Itimore	Ba	ltimor	•e					1 ☐ Yes 2 ☐No
	r 28a	rec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	untry?
	h with	al D	3132 Harview	Ave.				21234		Į	USA	
	ems ems	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces		i. 13.	Was Decedent of H	lispanic Origin? an. Mexican, Pu	(Specify Yes or No serto Rican, etc.)	0- 1	14. Race - Ame Black, White	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Modical Examiner must be notified at ance.	by	1 ☐ Never Married 2 ☐ N 3 ☐ Widowed 4 ☐ Divor	Married 1 ☐ Yes 2 ☐	₩o		1 □ Yes 2√2 No	Specify:	,	}	Specify: W	
5-0	72 ho natu	Completed		dent's Education ghest grade completed)		(Give	dent's Usual Occup kind of work done	durina most of	working	16b. Kir	nd of Business/	ndustry
121	within ane than	mp	Elementary/Secondary (0-1	2) College (1-4or n/a	5+)		yard Sca	,		Rati	hlehem	Stool
	filed v Hygie other I		17. Father's Name (First, Midd			Stock	yaru Sca		Name (First, Middle	-		Steel
Maryland	ould be f Mental P warked of	To Be	William A. St	arkey, Sr.				Lulu	Martin			
3	should nd Men marke umatic	-	19a. Informant's Name/Relati			19b. Maili	ng Address (Street	and Number or	Rural Route Numb	er, City or	r Town, State, 2	ip Code)
	and 2 salth a n 27 ls		Blossom Good	win/Caregiver	-	3132	Harview	Ave.,	Balto.,	MD 2	21234	
J.	ss 1 a of Hea item		20a. Method of Disposition	- 2	CO	ace of Dispo	osition (Name of matory or other place	ce) (0!	5/20/05	20c. Lo	cation - City or	Town, State
Ë	Pages nent of I ant: If its ury or o		'4 □Donation 5 □Othe	on 3 Removal from State r (Specify)	Dula	aney	Valley Me		Gardens	Time	onium,	MD
Baltimore,	permit. Departr Imports any inju		21. Signature of Funeral Sirv	Flagle		2:	2. Name and Addre	ss of Facility uneral	Home of	Dula	ney Va	lley, Inc. 093
	- 1		23a. Part1. Enter the disease		ed the death.	Do not en	ter the mode of dyir	ng, such as card	diac or respiratory a	arrest,	7.0	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	List only one cause on each		2. 4	1.0.V	. D.				Onset and Death
1	/Medical		resulting in death)	Due to (or a	s a conseque	ence of):						0110074007
В	Examiner		Sequentially list conditions	b								
7	₽ ≒	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a conseque	ence of):						
V	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or a	s a conseque	ence of):						
60,	be ey ician buria	alE				31100 01/1						
68760,		edical		d								
Box	The law requires that the death certificate has Feen signed by the attending plage 2 should be detached for use as t	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			7-			2	23d. Date of deli	very
	death e atte d for	icia	in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 4☐Pregnant			Dectopic pregnancy Other (specify)	<del>/</del>			Month	Day Year
P.0	that the de ned by the a detached t	Physician/M	9 Unknown	9□ Unknown								
	res tha igned l	by F	Part II. Other significant con-	ditions contributing to death	but not resul	lting in the u	inderlying cause giv	ren in Part I.				the cause of death?
ord	requir	ted							- ''-	Yes 2L	□No 3□Pr	obably 43 enknown
Records,	a law	Completed							24a. Was	psy	24b. Were au prior to death?	topsy findings available completion of cause of
<u>E</u>	: The cate I								1 ☐ Yes	ormed? No	1 Yes	2 No
Vital	Physician: this certificatal director, i	Be	25. Was case reterred to med examiner?	Hospital:			oth Oth	ar	Death (Check only			
o		To To	Yes 2 No 27. Manner of Death	1 ☐ Inpat		R/Outpatie 28b. Time o	II 3LI DOA	4 🗆 Nursin	g Home 5 Res			cify)
Division	ding th. After	tlon	Natural 5 □ Per	/Manth F	ay Year)	Injury	Wor	rk? Yes 2 □ No				
<u> </u>	Attendi r death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Co	uld not be emined 28e. Place of li	njury - At hor	ne, farm, st	reet, factory, office			(Street and		ral Route Number,
ā	s afte	Cert	4 Nomicos	building, 6	etc. (Specify)				City or 10	iwii, State)	,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attencompletely filled in by the fune	edical Certification:	29a. Certifier 1 Certi (Check only 2 Medi	fying Physician: To the bes cal Examiner: On the basis and manner s	of examination	rledge, deat on and/or in	h occurred at the tir evestigation, in my o	me, date and pl opinion, death o	ace, and due to the ccurred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
_	To th withir To th comp	Me	29b. Signature and title of cer	tifier &	2 = 7	> -	29c. Licens		30		e signed (Monti	
			00 None and address of	on who completed course of	doub (lac-	220) /Tun-	Print)	0 000		, ,	1	~   a.o.
	3		30. Name and address of per	IL SHA SI	4014	ARY	tw. M	· C.	G000) S	AMF	ARITA	2, 2005 NHOPITAL
	Sta	te	31. Date filed (Month, Day, Yo									
	Regist		MAY 1	9 2005 Maria	u U	600	ME					
DH	IMH 17 Rev 1/2	001	III/1 -	1000		-						

ORIGINAL

Registrar DHMH 17 Rev 1/2001

			1 - For State of Maryland / Dep	ertificate of		nd Mental Hy	giene	15 16922
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of De Month	nath Day	3. Time of Death
	/Media	cal	Sol M. Steinhorn	1		Mary	16 2	(0) 2 (0) M
	Examir	ner	4a. Facility Name (If not institution, give street and number) ATRIUM VILLAGE	4b. City, Town,		MILLS	4c. County	BALTIMORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		If Under 2	4 Hrs. 8 Date of Bir	th Vear	Birthplace (State or Foreign Country)
	Director		219-05-6919 1 MM 2 F 87 Yrs.	Months Days	Hours	SEP.30	1917	MD MD
	ow ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	_ocation				10d. Inside City Limits
	a-f eh	tor	MD BALTIMORE OWING	S MILLS				1 ☐ Yes 2 🔀 No
	or 28	Olrec	10e. Street and Number	10f. Zip Code			10g. Citizen of V	Vhat Country?
	e 23a	ral	4730 ATRIUM COURT #163		21117			USA
	fter de	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 0 No	. Was Decedent of If Yes, specify Cut	Hispanic Origi ban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Hace Blac	e - American Indian, k, White, etc.
ဗ္ဗိ	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow the Mudical Expiriting must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No	Specify:		Specify	WHITE
2	"natu	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occu e kind of work done DO NOT use retire	pation during most	of working	16b. Kind of Bu	siness/Industry
7	withir lene. than	duic	Elementary/Secondary (U-12)   College (1-4or 5+)	MATOR	∌d)		CONSTRI	JCTION COMPANY
2	e filed Il Hygik other	Be C	17. Father's Name (First, Middle, Last)	THE CITY	18. Mother	's Name (First, Middle		
ylar	should be nd Mental markad matic ev	ToE	HARRY STEIN		LENA			FEIGENBLUM
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or iteme 23a or 28a-1 ehow any injury or other treumatic event, the Medical Experiment must be notified at ance.					or Rural Route Numb		State, Zip Code)  3. IL 60610
ē,	of Healitem		20a. Method of Disposition 20b. Place of Disp			Date		City or Town, State
Ē	Pages ment of I ent: If it		*4 □Donation 5 □Other (Specify) CHIZUK A	MUNO ARLI	NGTON	5/18/2005		IMORE, MD
Balt	Depart Mport mport any inj					OL_LEVINSC		
			23a Part1 Enter the disease or complications that caused the death. Do not en					MD 21208 Approximate
	Physician		shock, or heert failure. List only one dayse on each line.  Immediate Cause (Final disease or condition	cheimer	,	15P458		Interval Between Onset and Death
ï	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	C A Lest As Leen	3 ()	1 DE 150		1003
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	ocuted nd transit	Examiner	that initiated events					
8760,	death certificate be executed e attending physicien and id for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):					
687	fficate g phys as the	edical	d					
ROX	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnanc	***			e of delivery
O.		Physician/Me		Other (specify)	·y		Mor	nth Day Year
ı.	res that the de signed by the a i be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause g	ven in Part I.	23e. Did t	obacco use contr	ibute to the cause of death?
rds,	requires that the leen signed by th hould be detache	ed by			_	10	res 2 25No	3 ☐ Probably 4 ☐ Unknown
Kecord	aw Is t	Completed				24a. Was		Vere autopsy findings available rior to completion of cause of
_	The ate h page	Com				perfo 1 ☐ Yes	rmed? d	eath?
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0	Attanding F r death. ector: After by the funer	atlon;	1∰Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Wo	ork? ]Yes 2∐No	o	. ,	
DIVISION	of or Attand after death Director: / d in by the f	Certificati	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office		28f. Location (3 City or Tox	Street and Number vn, State)	er or Rural Route Number,
_	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1—Certifying Physician: To the best of my knowledge, dea	th occurred at the t	me date and	place, and due to the	Cause(s) and mar	oner as stated
	To the Hospitei within 24 hours a To the Funeral completely filled	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my	opinion, death	occurred at the time,	date and place, a	and due to the cause(s)
	To t To t	Ž	29b. Signature and title of certifier		se number		29d. Date signed	(Month, Day, Year)
					/3757		May 1	6 5005
1	1		30. Name and address of person who completed cause of death (Item 23a) (Type	Reis	revstor	~ Mt	2113	6
	Sta		31. Date filed (Month, Day, Year) \$2. Registrar's Signature				- 1	
	Registr	ar	MAY 1 9 2005					

			1 - For State Registrar	State of Marylar		artment of H			iene	)5	16923
	Physic	ian	Decedent's Name (First, Middle, Lass     HERBERT	•		TIEMANN		2. Date of Deat MAY 16,		Year	3. Time of Death 7:15 P M
	/Medi Exami		4a. Facility Name (If not institution, give	E.			Location of Death		4c. County	of Death	7.13 F
	Exami		HOSPICE OF BALTIMO		CTR.		TOWSON		ВА	LTIMO	
	Funeral Director		5. Social Security Number 6. S 149–16–0155	9X 7. Age ( <i>in yr</i> s.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JUN. 20,	ݰa′) 1928	9. Birthp Cour	place (State or Foreign htty) NY
	and	1	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
٤	the Maryland 28a-f show	ctor	MD BAL	TIMORE	BALT	IMORE					1 □ Yes 2 🙀 No
4.	with th	Funeral Director	10e. Street and Number	W717		10f. Zip Code	21200	11	0g. Citizen of	What Cour	utry? USA
17	death ms 23a	era	7 SLADE AVENUE :	12. Was Decedent Ever in U	.S. 13. )	Was Decedent of Hi f Yes, specify Cuba	21208 spanic Origin? (Sp	pecify Yes or No-		ce - Americ	can Indian,
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygierie. Department: If item 27 is marked other than "natural", or Items 23e or 28a-1 show any Injury or other traumatic event, the Madical Examinational be notified at once.	by Fur	1 ☐ Never Married 2 🂢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 🗖 No	n, Mexican, Puerto Specify:	Hican, etc.)	Specif	ck, White, fy:	WHITE
	5-0	eted	15. Decedent's Ec (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occupa	luring most of work	king	16b. Kind of B	usiness/In	dustry
h	21215-0036 ad within 72 hours aff giene. er than "natural", or than "natural", or	Completed	Elementary/Secondary (0-12)	2 College (1-4or 5+)	i	DO NOT use retired ESALER	,		INSTIT	UTION	AL FOODS
00	Maryland of the strength of 2 should be filed the and Mental Hyg 27 is marked other traumatic event,	o Be C	17. Father's Name (First, Middle, Last) BENJAMIN		TIEM	ANN	18. Mother's Nam	ne (First, Middle, M	Maiden Sumai	71e)	KANNER
0	aryl should and Me s mark	은	19a. Informant's Name/Relationship (7	Type, Print)		ng Address (Street a		ral Route Number,	City or Town	, State, Zip	
و	and 2 ealth a m 27 i		ELAYNE TIEMANN		_	ADE AVENU					
	Baltimore, permit. Pages 1 as Department of Hea Important: If item any Injury or other once.		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cren	sition (Name of matory or other place	θ)		20c. Location		
786	altin		* 4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			MORIAL GA 2. Name and Addres		L LEVINS		Y, MD Ros	
4	W Figure 8		1 Roets	1	<u> </u>	900_REIST					
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or asia consec	ance	er the mode of dying	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	3760, ate be executed invision and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
Dert	. Box 68 death certifica e attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fete 4 Pregnant at time of o	ıl death 3 □	Ectopic pregnancy Other (specify)				ate of delive	eny Day Year
d	ecords, P.O law requires that the as been signed by th	by	Part II. Other significant conditions of	ontributing to death but not res	culting in the u	nderlying cause give	en in Part I.		acco use con os 2 □ No	1/	ne cause of death?
D	Records, he law requires the has been signed age 2 should be considered.	letec	Corevary	30000				24a. Was a	n 24b.	Were auto	psy findings available
_	al Rec	Completed						autops perform	head?	death?	mpletion of cause of
2	Vital siclan: T certificate irector, pa	) Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ED/Outpotion	othe	200	th <i>(Check only o</i> n	1	ner (Specif	(v) - 111 - 22 - 22 - 22 - 22 - 22 - 22 -
MANN	on of ding Phys h. After this funeral di	tlon: To	1 Yes 2 No  27. Manner of leath 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury Work	4 🗆 Nursing H	28d. Describe ho	- 1		Mospice
16	Division  I or Attending after death.  Director: After in by the fune	Certification;	3 Suicide 6 Could not by determined		ome, farm, str fy)	eet, factory, office		28f. Location (St. City or Town		ber or Rura	il Route Number,
1	Division of Vital Re to the Hospital or Attending Physiclan: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C		ysicien: To the best of my knowniner: On the basis of examination and manner stated.							
	To the within To the	Me	29b. Signature and till of certifier	1 -		29c. License	number	25	9d. Date signe	ed (Month,	Day, Year)
			Merca	/ My		1)25	503	N	roy 1	70	OOS
	0		30. N e a Fress of person who	completed cause of death (Itel	п 23а) (Туре,	Print)		6601 N. Towson,			reet
	St. Regist	ate rar	31. Date filed (Month, Day Year) NAY 1 9 2005	32. Registrar's Sign	ature	2					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) May P24 **Physician** 5:24 AM Velten Jr. Henry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Sept. | Months | Days | Hours | Min. | Sept. | Sept. | 374 | 4 | 1921 Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 83 214-12-0130 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Pasadena Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21122 8494 Jenkins Road items 23a Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Item any injury or other traumatic event, the Medical Examine 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Marine Engines Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Velten Velten Charles Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (son) 2062 Aberdeen Drive, Crofton, MD 21114 Dennis Velten 20c. Location - City or Town, State May 18 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Loudon Park Cemetery 2005 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility Stallings Funeral Home, P.A. 21. Signature F 3111 Mountain Road, Pasadena, MD 21122 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ease, or complications that 23a. Pert1. Enter the diseas shock, or heart failure. Immediate Cause (Final -; bros **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Yes 3 Probably 4 Unknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1 Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes B No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ind title of certifier 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) Stephen 31. Date filed (Month, Day, Year) gistrar's Signature Registrar

George Wolford 05-03376 MLN

**Funeral** Director

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mer	ntal Hygiene	005	
Cortificate of Death	line.	· O O O	

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the M Department of Health and Mental Hygiene.	ic ic
Division of Vital Records, P.O. Box 68760,	thanding Physician: The law requires that the death certificate be executed death. ctor: After this certificate has been signed by the attending physician and	the funeral director, page 2 should be detached for use as the burial-transit

	1	For State Registrar	Otate (	or warytar			of Death		eg. No.	5 16925		
esioion.		1. Decedent's Name (First, Midd	dle, Last)					2. Date of Dea Month		3. Time of Death		
/sician ledical	-		Geo	rge S.	Wolfor	d		May	•	005 1556 "		
aminer		4a. Facility Name (If not institution	-	umber)		4b. City, To	wn, or Location of Dea	ath	4c. County of	Death		
		3510 Bullfrog					eytown		Carro			
eral ctor		5. Social Security Number 220–58–5490	6. Sex 1 <b>25</b> M 2□F	7. Age (In yrs. 53	last birthday Yrs.	Months I				9. Birthplace (State or Foreign Country) Maryland		
328	-	Usual Residence of Decedent  10a. State 10b. Count	v	10c. C	ity, Town or t	ocation				10d. Inside City Limits		
b	- 1		_	***						1 ☐ Yes 2 ☒ No		
Director	5	Maryland Car  10e. Street and Number	roll	we	stmins	10f. Zip C	ode		Og. Citizen of Wh	at Country?		
						75.1.2.5	21157					
Inar cust	5	303 Denton Dri		cedent Ever in U	J.S. 13	. Was Deceder	nt of Hispanic Origin? (	(Specify Yes or No-	United 14. Race	American Indian,		
		1 ☐ Never Married 2 ☐ Ma	Armed F 1 Tes If Yes, G	2 🛛 No			/ Cuban, Mexican, Puè ☑ No <i>Specify:</i>	erto Rican, etc.)	Black, Specify:	White, etc.		
b		3 ☐ Widowed 4 ☑ Divorce	d Year or			100 24	s ito openy.			White		
Completed		15. Decede (Specify only high	nt's Education est grade completed	)	(Giv	edent's Usual e kind of work	done during most of w	rorking	16b. Kind of Busi	ness/Industry		
ion ion		Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT use	ŕ					
9		12 17. Father's Name (First, Middle	a / act)			Superi	itendent	ame (First, Middle.		ction Comp.		
Be va	í								vialueri Surrame)	'		
	O Alfred W. Wolford Hettie Wadell  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z									Into Zin Codol		
in in in in in in in in in in in in in i										105=1		
The the	ŀ	Jami Wolford/ 20a. Method of Disposition	Daugnter	20b.		Waccama position (Name	w Pines Dr		Beach. 20c. Location - C			
0		1 Burial 2 Cremation		n State	cemetery, cr	amatory or oth	<sup>er place)</sup> May	23,2005		•		
de .	`4 Donation 5 Other (Specify) Metropolitan Crematorium Inc. Alexandria, Virgin											
once		21. Signature of Funeral Service Licensee Olin L. Molesworth P. A. Funeral Home 26401 kidge koad, Damascus, Maryland 20872										
		23a Part1 Enter the disease	or complication that	caused the dea						Approximate		
fig.	1	23a. Part1. Enter the disease, o shock, or heart failure. Lis	st only one cause on	each line.	/	- / -	or dying, soon as our as	ao or respiratory arr	031,	Interval Between Onset and Death		
ian cal		Immediate Cause (Final disease or condition resulting in death)	- a. Hel	adan	el no	ek,	njune	N				
ner		<b>3</b>	Due to	o (or as a conse	quence of):		O					
- a		Sequentially list conditions if any, leading to immediate	b. Due to	o (or as a conse	quence of):							
Examiner		Cause (Disease or injury	≺	,	4							
Xai		that initiated events resulting in death) Last	c	(or as a conse	quence of):							
ie			d									
cian/Medical Examir			G									
		IF FEMALE: 23b. Was decedent pregnant		utcome of pregn					23d. Date	of delivery		
C.		in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2 ☐ Fet nant at time of		□Ectopic pred □ Other (spec			Month	n Day Year		
Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown											
by P		Part II. Other significant condit	tions contributing to	death but not re	sulting in the	underlying cau	se given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?		
								1 🗀 Y₁	es 25 <b>74</b> 3	☐ Probably 4 ☐ Unknown		
ompieted								24a. Was a		ere autopsy findings available		
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Ö	-	25. Was case referred to medic	al	· · ·	·		26. Place of D	1,△.Yes eath (Check only or		N 95 2 1 140		
.0	1	examiner? 1X Yes 2 No	Hospital:	Inpatient 2	] ER/Outpatie	ent 3 DOA	Other			(Specify) Scene		
	1	27. Manner of Death	28a. Date	of Injury	28b. Time	-	. Injury at	28d. Describe he	ow injury occurred	Tax Orange U.O.		
ertification		1 Natural 5 Pend	ling tigation	nth, Day Year)	Injury	1PM	Work? 1 ☐ Yes 2 ☑ No	Lent roa	d diviru	)   [		
. E		3 ☐ Suicide 6 ☐ Could	mined 286, Plac	e of Injury - At h	nome, farm, s	treet, factory,	phice	28f. ocation (S	reet and Number	or Rural Route Number.		
ert		4 Homicide	Dulle	ding, etc. (Spec	dha	roac	(	Tarrenton	M, MD C	5 Bullerou Rd.		
Medical Certification: To Be Completed by Physician/		29a. Certifier 1☐ Certify	ing Physicien: To th	ne best of my kn	owledge, dea	ith occurred at	the time, date and place	ce, and due to the c	ause(s) and mann	ner as stated.		
edical		(Check only  Medica		basis of examin	ation and/or i	nvestigation, ir	my opinion, death oc	curred at the time, d	ate and place, an	d due to the cause(s)		
ž		29b. Signature and title of certif	ier	,			icense number	2	9d. Date signed (	Month, Day, Year)		
			And V	N			OCME		May, 16,	2005		
2	1	30. Name and address of perso	n who concluded cau	use of death (Ite	m 23a) (Type	, Print)			-			
3		S.R.H	OGAN	)		111 Pe	nn Street	Baltimor	e, Maryl	and 21201		
State	h	31. Date filed (Month, Day, Yea		Registrar's Sign								
gistrar	, j	MAY 1	9 2005	Stague.	K.	Speck						
v 1/2001												

DHMH 17 Rev 1/2001

**ORIGINAL** 

			State of Maryland / Department of Health and Months    1 - State Registrar	ental Hygiei Reg.	
				2. Date of Death	3. Time of Death
	Physicia		Barona C. Ziegler	MG-1 17	18, 20 N 5 5 20 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death
			North Armael Hospital Glen Burn	3.8	Hun Humas
	Funeral		5. Social Security Number 6. Sex 7. Age (In rs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
	Director		187-09-5379 93 IIS. Usual Residence of Decedent	Nov. 1, 1	1911   Pennsylvania
	/land		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Man e-f sh	to	Maryland Anne Arundel Glen Burnie		1 ☐ Yes 文⊠ No
	or 28	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	23a		12 Roosevelt Ave. 21061		nited States
	ar dez	nue	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1946-  13. Was Decedent of Hispanic Origin? (Specific Version Procest)  14. Was Decedent of Hispanic Origin? (Specific Version Procest)  15. Was Decedent of Hispanic Origin? (Specific Version Procest)	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1940 1 □ Yes 2 □ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:		Specify: White
Š	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28e-f show ant. The Medical Exampler must be mailfied at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	16b	. Kind of Business/Industry
215	thin 7.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)	ig	
7	ygien ygien er th	Con	12 Customer Relations		nufacturing
pu	be fill	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name		oen Sumame)
څ	d Mer nark natic	ို	Charles Ziegler Laura  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural	Moyer	ity or Town State Zin Code)
Maryland 21215-0036	d 2 sho th and h			Burnie,	
	Heal Heal tem 2	i	20a. Method of Disposition 20b. Place of Disposition (Name of computery, grantony or other place) Maximum	ate 20c	Location - City or Town, State
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Menta! Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event. The Medical Experient must be conflict at ones.		21 Signatur Funeral Service Licensee 22. Name and Address of Facility		
m	89 = 8		Firkley-Ruddick Fune	Glen Bürr	nie, MD 21061
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one decise on each line.	r respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		Chisti and Douin
	/Medical Examiner		Due to (or as a consequence of):		one day
		ē	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):		
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events		
ó	an an rial-tr		resulting in death) Last Due to (or as a consequence of):		
8760,	icate be executed physician and s the burial-transit	dicai	d		
9	artifica ing ph e as t	Med	IF FEMALE:		
Box	law requires that the death certificase been signed by the attending to should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?		23d. Date of delivery  Month Day Year
P.0.	he de	ysic	1 Yes 2 No 9 Unknown 9 Unknown		
۳.	that the the the the the the the the the th		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
rds	w requires that been signed by should be det	ed by	Vementa	1 ☐ Yes	2 No 3 Probably 4 □Unknown
00	s bee	piete		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	0 4 6	Completed		performed	? death?
Vital Records,	ilclan: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	(Check only one)	
of V	Physician: this certific ral director,	ပ္	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom		e 6 Other (Specify)
n C	Attending For death.  ector: After by the funera	lon:	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how it	njury occurred
Division	death.	icat	2 Accident		t and Number or Rural Route Number,
2	5 0 0 ×		4 ☐ Homicide building, etc. (Specify)	City or Town, S	tate)
	al or Att	ertif			
۵	ospital or Att hours after d Ineral Direct y filled in by	cai Certification:	29a. Certifier  Cherk only  Adding Everning: On the best of my knowledge, death occurred at the time, date and place, a	and due to the cause	e(s) and manner as stated.
۵	the Hospital or Att in 24 hours after d the Funeral Direct pletely filled in by	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ed at the time, date	and place, and due to the cause(s)
Ö			(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre	ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)  Date signed (Month, Day, Year)
ia	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of deriffier  D 4 8 0 0 6	ed at the time, date	and place, and due to the cause(s)
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ia	9	Medicai	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.  29b. Signature and title of deriffier  29c. License number  D + 8 v v b  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ed at the time, date	and place, and due to the cause(s)
٥	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Total Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely filled in by the Direct completely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of dentifier  29c. License number  D 4 8 0 0 6  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ed at the time, date	and place, and due to the cause(s)

@ Berong

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** THOMAS **JEFFERSON** ARKINSON JR. MAY 8 2005 9:150 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Wing - Heron Point Chestertown Kent If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Mar 9 Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**☑**M 2□F 86 Yrs. New 720-16-7088 **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State ms 23a or 28e-f shov 1 gyYes 2 □ No Director MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 316 Heron Point 21620 U.S.A. death Funeral Race - American Indian, Bfack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 157es 2□No 1941 IfYes, Give Year or Dates: -1945 1 ☐ Never Married 2 ☑ Married è Baltimore, Maryland 21215-0036 1 ☐ Yes 2/2 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ing most of working Elementary/Secondary (0-12) College (1-4or 5+) Thoroughbred Horse Trainer Self-employed 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any july or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Thomas J. Arkinson, Sr. Mildred Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Arkinson (wife) 316 Heron Point Chestertown, MD. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 ☑ Cremation 3 ☐ Removal from State 5/9/05 Kent Cremation \* 4 ☐ Donation 5 ☐ Other (Specify) Smyrna, DE. 22. Name and Address of Facility
Galena Funeral Home of Stephen L.
118 West Cross St. Galena, MD. 21 21. Signature of Funeral Service Licenses Schaech M00510 Approximate Interval Between Onset and Death Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cancer /Medical Due to (or as a consequence of): **Examiner** Adeno Carcinoma Sequentially list conditions, if any, leading to immediate sease. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) o detached 9 Unknown 9 ☐ Unknown Division of Vital Records. P. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 2 🔯 No 1 ☐ Yes 2 X No after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitaf. Other: 4½ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 7 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29d. Date signed (Month, Day, Year) 296. Signature and title of certifier 29c. License number 641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21620 Patrick J. Shanahan, M.D. 120 Speer Rd. Blda. B Chestertown, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State of Maryland / Department of Health and 1- State Registrar Amend #21. Per FH PCC 5-6-05 cr Certificate of Death	Mental Hygi	ienie	16928	3
0	- W		Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Deat	
	Physicia /Medic	al	Pauline A. Antoine	5		10.008	a M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dec		4c. County of		
			11700 Old Columbia Pike #1115 Silver Sprin			gomery  Birthplace (State or Form	mian
	Funeral Director		5. Social Security Number 2 16-19-5872 6. Sex 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Park 1 Months Par		914 S	T. Vincent	WI
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Lin	mits
	Mary Fred	ţ	MD. Montgomery Silver Spring			1 TYes 2□	]No
	th the	Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of Wh		
	23a c	aiD	11700 Old Columbia Pike #1115   20904			Indies	
	r dea	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put	(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc.	
9	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 🖼 No Specify: Year or Dates:		Specify:	Black	
ခို	72 hours after death with the Maryland Inatural; or Items 23s or 28s-f show Jisal Examiliar must be notified at		15 Decedent's Education 16a Decedent's Usual Occupation		16b, Kind of Busi	ness/Industry	
Maryland 21215-0036	in 72	piet	(Specify only highest grade completed)  Elementary/Secondary (0.12)  College (1-4or 5+)  (Give kind of work done during most of with DO NOT use retired)	vorking			
212	be filed within 72 hours after death with the Marylan ital Hygiene. id other then "natural", or flems 23a or 28a-f show seen!, the Macified Examilment and seen!	Completed	12th domestic		Privat	e	
פ	be filed hal Hygie nd othar svent,	Be (		lame (First, Middle, M	Maiden Sumame)		
<u>ya</u>	should be ind Mental i markad umatic sv	<sup>o</sup>	Wickcliff Jackson Rose	Oliver	0: 7 0	7. 0. (1)	
Jar	a a a a a a a a a a a a a a a a a a a		19a. Informant's Name/Relationship (Type, Print)  Sandra Caesar/daughter  5705 Kennedy Street				
	s 1 and 3 if Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)			ity or Town, State	
Baltimore,	Pages nent of h int: if ite iry or o		14 Burial 2 Cremation 3 Premoval rom State	/11/05	Adelph	i. MD.	
<u>=</u>			21 Singly of Funeral Service Videnses 1401 18 10 M. L. 1 22 Name and Address of Facility	43	20 H St	reet N.E.	_
Ba	permit. Departr Importa any Inju		Morry B.K. Henry FHC.	,INC. Wa	sh.,DC	.,20002	
2	Pnysician /Medical		Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cerebrovas uld  Due to (or as a consequence of):	iac or respiratory arre	est,	Approximate Interval Between Onset and Death	n ;h
68760,	Examiner  ysician and be burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.			YEARS	
.O. Box	The law requires that the death certificate tate has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date Mont		
۵.	w requires that s been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol		oute to the cause of death	
200	quire an sig uld b	ed b	ADVANCED HLZHEIMERS DISEASE	_ 1 □ Ye	es 2□No 3	Probably 4 Dunkn	10Wf
Vital Records,	The law re te has bee age 2 sho	Completed by	PARKINSONS DISEASE	24a. Was a autops perform	med? pri	ere autopsy findings avail or to completion of cause ath? □ Yes 2 □ No	
ita	ysician: The is certificate hadinector, page	a		Death (Check only or			
>		ToB	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursin		ence 6 Other		
n of	ding Pt. After th		27. Manner of Death  1 Natural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  28c. Injury at Work?	28d. Scribe he	ow injury occurre	d	
Division	or Attendi after death. Director: A d in by the fu	Certification:	2 Accident investigation investigation 3 Suicide 4 Homicide investigation  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town		r or Rural Route Number,	
_	Hospita 24 hours Funeral	edical Ce	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death o and manner stated.	ace, and due to the c ccurred at the time, d	ause(s) and man late and place, ar	ner as stated. nd due to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed	(Month, Day, Year)	
		1	Finday Decenso DZ142	8	MAY 3	, 2005	
•	CF12		30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)  LINDA D GREEN MD 7582 ANNAPOUS R	HUAJ C.	7M MA	20784	
	St. Regist	ate	31. Date filed (Month, Day, Year)  2. Registrar's Signature				

Physici /Medic		1 - For Unpend Item Registrar  1. Decedent's Name (First, Middle, L		ATWELL				2. Date of De Month	aath Day	, Y	3. Time of Death	
	al	4a. Facility Name (If not institution, gr			4h Cihi	Tour or	Location of Deat	MAY	12,	2005 County of	0836 A	
Examir	er	CARROLL HOSPITAL			1	MINS.			1	ARROL		
uneral irector		219–13–3337	Sex 7. Age (I	n yrs. last birthday, 23 Yrs.	Months	1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bi Month, Di Sept. 1	rth Y926	81	. Birthplace (State or Forei Maryland	
W W		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or L	ocation						10d. Inside City Limit	
Miller	ctor	Maryland Carro	11	Westmir							1 □ Yes 2√X N	
then	i Dire	10e. Street and Number 2416 Mayberry	Road		10f. Zip	10f. Zip Code 21158				izen of Wha USA	at Country?	
the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ★ Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.	Was Deced If Yes, spec		spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or Noto Rican, etc.)	0-	Black,	American Indian, White, etc. White	
	Completed by	15. Decedent's (Specify only highest g	Education	16a. Dece	edent's Usua e kind of wo	al Occupa	tion uring most of wo	rking	16b. Ki	nd of Busin	ness/Industry	
	mple	Elementary/Secondary (0-12)	College (1-4or 5+)				uring most of wo		St	ate H	ospital	
	To Be Co	17. Father's Name (First, Middle, Last)  George F. Atwell, Sr.  18. Mother's Name (First, Middle, M.  Lennie Hips								aiden Sumame)		
other treumatic eve	-	19a. Informant's Name/Relationship Lennie Atwell/r						ural Route Numb stminste	-		ate, Zip Code) 158	
or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cre	ematory or o	other place		Date	22		ty or Town, State	
Jury .		'4 ☐Donation 5 ☐ Other (Special Service Lice)	rify)	Harmony	Cemet 2. Name ar		of Equilibr				endship, MD	
once		John M. X	tiles				S	tiles Fu St., Tan	nera eyto	l Hom wn, M	e D 21787	
burial-transit	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Joissase or injury that initiated events resulting in death) Last	b. Due to (or as a c									
2000	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ★ Unknown	23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at tin	Fetal death 3	□Ectopic pi □ Other (sp					23d. Date o Month		
To the Hospitel or Attending Physicien: The law requires that the deeth certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettending physicompletely filled in by the funeral director, page 2 should be detached for use as the	by	Part II. Other significant conditions	contributing to death but i	not resulting in the	underlying o	ause give	n in Part I.			co use contribute to the cause of death?  2 No 3 Probably 4 Unknown		
uld be detach	0									prio	re autopsy findings availab ir to completion of cause of th? Yes 2 \( \text{No} \)	
page 2 should be	Completed								1	,		
rector, page 2 should be	Be	25. Was case referred to medical examiner?	Hospital:	0 - 50/0		Othe	p.	ath (Check only		0 0015	(0	
funeral director, page 2 should be	To Be	examiner? 1 X Yes 2 No  27. Magner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	2 ER/Outpatie (ear) 28b. Time (njury	-	28c. Injury Work	r: 4 🗆 Nursing t	ath (Check only Home 5 - Res 28d. Describe	idence		(Ѕрвсіfу)	
y the funeral director, page 2 should be	To Be	examiner? 1   Yes 2 No  No  No  No	28a. Date of Injury (Month, Day )	(ear) 28b. Time (Injury)	of 2	28c. Injury Work	r: 4 Nursing t at ?	Home 5 ☐ Res 28d. Describe	idence how injui	y occurred	(Specify) or Rural Route Number,	
to. After this certificate has been significate the funeral director, page 2 should be	o Be	examiner?  1 X Yes 2 No  27. Magner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine  29a. Certifier 1 Certifying 8	28a. Date of Injury (Month, Day )	28b. Time Injury  At home, farm, s (Specify)  my knowledge, dea camination and/or it	of 2 M treet, factor	28c. Injury Work 1 🗆 Y	A Nursing bat at ? 'es 2 No	28d. Describe 28f. Location City or To	(Street and who, State	y occurred  od Number  )  and mann	or Rural Route Number, er as stated.	

State of Maryland / Department of Health and Mental Hygiene

		C	Certificate of Death	Reg	J. No.	10330
		1. Decedent's Name (First, Middle, Last)		2. Date of Deeth		3. Time of Death
	Physician	Raymond Owen Miller Brown		April 28	Dey Year	6:00PM
	/Medical Examiner	4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or L		4c. County of Deeth	
1	Examine:	501 Lourdes Drive	Fort Wash	ington	Prince Ge	orge
	*Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho			9. Birth	place (State or Foreign
1	Director	578-10-3232 12 M 2□F 90 Yrs	s. Months Days Hours Min.	March 9,	1915 Wash	ington, D.C
	land w	10a. Stete 10b. County 10c. City, Town of	or Location			IOd. Inside City Limits
	Ba-f shu		ngton, D.C.			1 May Yes 2 □ No
	3 or 2	1708 D Street S.E.	10f. Zip Code 2003		. Citizen of What Cour nited State	
0	be filed within 72 hours efter death with the Maryland tall hyglene.  de thyglene.  de thy return "naturel", or items 23e or 28e-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director.	11. Maritel Status  1□ Never Merried 2□ Married  12. Was Decedent Ever in U,S. Armed Forces?  1□ Never Merried 2□ Married  12. Was Decedent Ever in U,S. Armed Forces?  1□ Never Merried 2□ Married It Yes, Give	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerton 1 1 Yes 2 № No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: B1a	etc.
20	ours Dy	3 ☑ Widowed 4 ☐ Divorced Year or Dates:				
7	72 h	15. Decedent's Education (Specify only highest grede completed) (G	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	king 16	b. Kind of Business/In	dustry
0200-91212	be filad within 72 hou tal Hygiena. I other than "nature yent, the Medical E	Elementery/Secondery (0-12) College (1-4or 5+)	rinter		Federal Gov	vernment
	Hygh other ent, tent	17. Father's Neme (First, Middle, Last)		ne (First, Middle, Ma		
yland	Vantal riked of rific ev	Charles Brown	Flore	nce Butle	r	
	of Dr.	19a. informant's Name/Relationship (Type, Print) 19b. N	Nailing Address (Street and Number or Ru	rel Route Number, C	ity or Town, State, Zip	Code)
2	alith a	Paul D. Brown/Son 200	06 Catherine Fran D	rive; Acco	keek, MD.	20607
aitimore,	of Han Item	20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from State  20b. Place of D cemetery,	isposition (Neme of crematory or other place)	Date 20	c. Location - City or To	own, State
Ĕ	nit. Pagas artment of l ortant: If Ik Injury or o			ay 6,2005	Clintor	n, MD.
משונ	Dapartr Dapartr Importu any Inji	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Pope Funer 5538 Marli	al Homes oro Pike	7.7
		ma X Sijekel		Forestvill	-	0747
	4.	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiad	or respiratory arrest		Approximate Interval Between Onset and Death
ا ۱	Physician /Medical	Immediate Ceuse (Final	the sand	Mari		Tin.
	Examiner	disease or condition resulting in death) a.	2.0	juice	<u> </u>	5-
	iner in a	Due to (or as e cor	isequence of):		1	0
,	cartificeta be executed adding physician and use as the burial-transit n/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury	isequence of):			
09/90	ysicla ysicla na bur	Ceuse (Disease or injury that initiated events resulting in death) Last	isequence of):			
8		resulting in deathly cast				
ĝ n	tendi srusi	d				
	at the deeth control of the ettend atechad for us Physicians	Part II. Other significent conditione contributing to death but not resulting in the	ne underlying cause given in Pert I.	23b. Did toba	ecco use contribute to	the cause of death?
ř	ires that the deeth car signed by tha ettendin d ba datechad for usa d by Physician/N			1 ☐ Yes	2X No 3 ☐ Prof	bably 4 Unknown
	negu Dean Shoul			24a. Wes en a performe	d? av.	ere autopsy findings ailable prior to mpletion of cause death?
r	Tha lew seta hes t page 2 s			1 J Yes	2K No 10	∃Yes 21€0 No
	cartificeta ractor, pag	25. Was case referred to medical	26. Place of Dea	th (Check only one)		
5	fending Physician: faeth. for: Aftar this cartific tha funarel diractor, cation: To Be (	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpa			e 6 ⊠Other (Specif	Son Charles Waddress
Sion	ding P. Aftar t funare	27. Manner of Deeth  1 ☒ Naturel 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Dey Year) Inju		28d. Describe how	injury occurred	
	To the Hospital or Attending P without 24 hours after death. To the Funeral Director: After 1 complately filled in by the funeral Medical Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rure State)	al Route Number,
ב	pital o burs al fillad i	29a. Certifier 1XI Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place	and due to the ceus	se(s) and manner as s	tated.
	the Hospital hin 24 hours the Funeral I nplately filled	(Check only one) 2 Medical Examiner: On the basis of examination end/o and manner stated.				
	Within To the complete Me	29b. Signature and title of certifier	29c. License number	29d	Date signed (Month,	Day, Year)
	-10-	1 w	D-2453	50	5.05	05
6	7 3	30. Neme end address of person who completed cause of death (Item 23e) (Ty	pe, Print)			
1	/	Laxmi Berwa, M.D., 7700 Old Branch	Avel, Suite ClO1,	Clinton,	MD. 20735	
	State Registrar	31. Dete filed (Month, Day, Year)  32. Registrar's Signature				

			1 - State Registrar	e of Maryland		artment of H			giene Reg. No. 005	16931
	Dhuaisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Yea	3. Time of Death
	Physicia /Medic		Loretta L. Butler					April	26 200	
	Examin	er	4a. Facility Name (If not institution, give street ar	nd number)		4b. City, Town, or			4c. County of D	
			Suburban Hospital  5. Social Security Number 6. Sex	7. Age (In yrs. la:	st hirthday)	Si:	Lver Sp	oring Hrs. 8. Date of Birt		gomery Birthplace (State or Foreign
	Funeral Director		577-34-4561 1□M 20		Yrs.	Months Days		Min. (Month, Da	y, Year)	Country) Maryland
			Usual Residence of Decedent							iai y iaiid
	how		10a. State 10b. County	10c. City,	Town or Lo		1 .			10d. Inside City Limits
	Ba-f s	cto	DC				ashing 			1X Yes 2 □ No
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	-
	s 23s	Funeral	910 Eastern Av	Decedent Ever in U.S.	12.1	Man Decedent of H	20019			ed States merican Indian,
മ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel; or Items 23a or 28a-f show aumatic event, the Mactical Examination and be invitted at		1 Never Married 2 Married 1	ed Forces? Yes 217 No				n? (Specify Yes or No- Puerto Rican, etc.)	Black, W	hite, etc.
Ř	ours a	Completed by	3 ☐ Widowed 4 ☐ Divorced Yea	r or Dates:		1 ☐ Yes 2]X No	Specify:		Specify:	Black
2	72 h "natu	ete	15. Decedent's Education (Specify only highest grade comple	eted)	(Give	tent's Usual Occup kind of work done	during most o	f working	16b. Kind of Busine	ess/Industry
2	within ne. then	m		ege (1-4or 5+)	ine. i	DO NOT use retired	•		G	
2	Hygie ther ant, it	ပို	12th 17. Father's Name (First, Middle, Last)			Secre		Name (First, Middle,		cnment
Maryland 21215-0036	ld be ental ked o ic eve	To Bo	Unknow	n				Della	Noland	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type, Prin	1)	19b. Mailir	ng Address (Street	and Number	or Rural Route Numbe	er, City or Town, State	e, Zip Code)
2	and 2 ealth a n 27 l		William Graham/Neph					n Dr., Bow	ie, MD 20	0716
Baltimore,	of H		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	from State 20b. Pla	ce of Dispo metery, cren	sition (Name of matory or other place		Date	20c. Location - City	or Town, State
Ē	permit. Page Department of Importent: If any injury or once.		`4 □ Donation 5 □ Other (Specify)	Har		Memorial		/2/2005	Landove	
Bai	Depar Depar Impor any in		21. Signatule of Funeral Service Licensee	L HTT	22			Stewart F		
			23a. Part1. Enter the disease, or complications shock, or heart lailure. List only one cause	that caused the death.	Do not ent	er the mode of dvin	u. such as ca	rdiac or respiratory ar	rest.	Approximate
			shock, or heart lailure. List only one cause Immediate dause (Final	on each line.	0.	1	1	Arr.	10.1	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in de th)	to (or as a consequently pe	ence of):	vascu	Jan	pres.	aen	-
	Examiner		Sequentially list conditions	hype	rt	entio	24			.ur
	ם א	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	is to (or as a conseque	ence of):					
	and and I-trans	Examiner	that initiated events	e to (or as a conseque	ance of):					
8760,	icate be executed physician and s the burial-transit	a E		.0 (0) 43 4 001130400	,,,,,,					
687	certificate be executed iding physician and use as the burial-transit	edical	d							
Вох	eath certific attending p	Z		s, outcome of pregnand Live birth 2 Petal of		Testania aragnana			23d. Date of	delivery
_ •	000	Physician/Me	1 Yes 2 No	Pregnant at time of dea Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
о. О	The law requires that the de te has been signed by the cage 2 should be detached	Phy	9 🗆 Unknown		N 1 - 40		. to Book	22a Dida	-hihh	a to the accuse of death?
Ś	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing	g to death but not result	ling in the ui	nderlying cause giv	en in Paπ I.			e to the cause of death?  Probably 4 🗷 Unknown
0.00	requ	eted								
Vital Records,	eicien: The law certificate has b irector, page 2 s	ompleted						24a. Was autop		autopsy findings available to completion of cause of 1?
Ø		e Co	25. Was case referred to medical					1 Yes	2 No 1 □ Y	′es 2□ No
5	eicie s cert	o Be	examiner?  1 Yes 2 X No  Hospital:	1 Minpatient 2 ☐ E	R/Outpatien	nt 3□ DOA Oth		Death (Check only only only only only only only only		inacifu)
10	Attending Physicien: It death. sector: After this certific. by the funeral director.	-	27. Manner of Death 28a.		28b. Time of		y at	-	now injury occurred	poony
0	ath. r: After	atlo	1 Natural 5 Pending 2 Accident investigation	(World), Day Year)	Injury		Yes 2 □ No			
Division of	or Attency after death Director:	Certification;	3 Suicide 6 Could not be determined 28e.	Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, lactory, office		28f. Location (5 City or Tow		Rural Route Number,
	spitel cours af							<u> </u>		
	Hos 24 h Fur stely	edical	29a. Certifier  (Check only one)  1 Certifying Physician: 1  2 Medical Examiner: On and							
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Me	onth, Day, Year)
4			> Ethropia H	sebe w	VD.	BAS	7411	91	April 2	9, 2005
(1)	L (4)		30. Name and address of person who completed	cause of death (Item 2	23a) (Type,	Print)		3.6		D 007/0
7			The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	pia Hbebe, Registrar's Signatu			th Way	, Marlow H	ieights, M	D 20748
	Sta Registr		31. Date liled (Month, Day, Year) MAY 0 6 2005	2. Registrar's Signatu	ha	les .				

CPM 05-03067 Jane Brathwaite

		•	For State Registrar	State of	Maryland / De	epartment of F Dertificate of			giefie 0 0 5 Reg. No.	16932
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	03, 2005	3. Time of Death
	/Medic		JANE BRATHWAIT			AL CIL Town	-1	May	4c. County of Deat	13:12 P M
	Examin	er	4a. Facility Name (If not institution, give s Prince George's Ho			Che	r Location of Death EVerly		Prince	George's
	Funeral Director		3//-08-0118	M 200 F	Age (In yrs. last birthe	Months Davs	Hours Min.	8. Date of Birt (Month, Day July 31	y, Year) 9. Birt Co 1, 1969 Was	hplace (State or Foreign untry) hington, D.C
	and w	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town of	or Location				10d. Inside City Limits
	Manyl.	tor	Md Prince Ge	orge!s	Uni	oer Marlbon	·n			1 XYes 2 ☐ No
	r 28a	rec	10e. Street and Number	orge s	ОР	10f. Zip Code	.0		10g. Citizen of What Co	untry?
	h with	a D	12418 Alamance Wa	.y		2077	72		United Star	tes
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Mcdcal Examinal must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Ford	□No	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: B1	e, etc.
5-0036	2 hour	ted t	15. Decedent's Educ	ation	16a. D	ecedent's Usual Occup Give kind of work done	pation	tina	16b. Kind of Business/	Industry
21215	thin 7:	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4	for 5+)	sive kind of work done ife. DO NOT use retire	during most or wor d)	king		
S	filed wi Hygien other th	Con		3Y:	rs Lat	oratory	Techicia		Medical	
Maryland	s 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Mental and the Mental and the Mental and the Mental and the Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental a	Be	17. Father's Name (First, Middle, Last)  James Hawkins				Theresa		Maiden Surname)	
2	should and Men marke umatic	ဥ	19a. Informant's Name/Relationship (Type	e. Print)	19b. N	Mailing Address (Street			er, City or Town, State, 2	Zip Code)
	and 2 sealth and 2 sealth and 27 is nor trau		Guy Brathwaite/Hu			418 Alamana				20772
<u>6</u>	of Heal		20a. Method of Disposition		cemetery	hisposition (Name of crematory or other place	ce)	Date	20c. Location - City or	Town, State
Ë	Page nent o int: If iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from Si	ate	Vet. Ceme			Cheltenham,	
Baltimore,	permit. Pages: Department of H Important: If ite eny injury or ot once.		21. Signatur of uneral Service Licens	John	or-Islley		and Ave.	, N.E. W	pitol Mortu Mash., D.C.	-
			23a. Parth. Enter the disease, or complishock, or heart failure. List only of	ations that ca e cause on ea	used the death. Do			or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition resulting in death)	Sn	whe in	balatio	70			Oriotic and Double
	/Medical Examiner		resulting in deality	Due to (o	r as a consequence of	):				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consequence of	:				
	uted d ansit	Examiner	Cause (Disease or injury that initiated events							
o,	an an arial-tr	Exa	resulting in death) Last	Due to (o	r as a consequence of	:				
8760,	icate be executed physician and s the burial-transit	dlcal								
.O. Box 6	ne death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 975€Inknown	1 Live bir	ome of pregnancy th 2  Fetal death nt at time of death vn	3 ☐ Ectopic pregnance 5 ☐ Other (specify)	у		23d. Date of del Month	ivery Day Year
4	that the		Part II. Other significant conditions con	tributing to dea	ath but not resulting in t	he underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
rds	w requires that s been signed b should be deta	d by						101	res 2 ⊠No 3 □ Pr	robably 4 Unknown
Records,	sician: The law rec ; certificate has bee irector, page 2 shor	Completed							an 24b. Were au prior to rmed? death?	utopsy findings available completion of cause of
Vital	ilan: artifica ctor, p	BeC	25. Was case referred to medical					ath (Check only o		
of V		ို	1₽Ares 2□No		patient 2 ER/Outp	attent 3 00A			dence 6 Other (Spe	cify)
	A 0 0	atlon:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	Total .	, Day Year) Inj	ury Wo	ryat rk? ]Yes 2⊠No	Do Claud	now injury occurred all	fon fine
Divi	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fun	Certification:	3 ★Suicide 6 Could not be determined	buildin	of Injury - At home, fam g, etc. (Specify)	, street, factory, office		28f. Location (S City or Tov	Street and Number or Air vn. State) 12418 Ly Mulboro.	Alamanel
	Hosp 24 hou Fune tely fill	Medical	29a. Certifier 1 Certifying Physical Check only one)	er: On the ba	sis of examination and/	death occurred at the ti or investigation, in my	me, date and place opinion, death occu	a, and due to the arred at the time,	cause(s) and manner as date and place, and due	s stated. a to the cause(s)
	thin 2 the mplet	Med	29b. Signature and (le of cg. if er	and mann	er stated.	29c. Licens	se number		29d. Date signed (Mont	h, Day, Year)
	£ 3 € 8		1/1/10	ALO	( /V	OCME			May 04, 20	
C	R 6		30. Name and address of person who co	mpleted cause	of death (Item 23a) (T	ype, Print) 111	Penn Stre	eet Bal		yland 21201
	Sta	ate	31. Date filed (Month, Day, Year)	. Re	gistrar's Signature	1.11.				
	Regist		MAY 8 6 2005	110	gistrar's Signature					

			1 - For State Registrar	State of M	1arylan		artmen rtificat			nd M		giene Reg. Nö		16933
	O. ,		1. Decedent's Name (First, Middle, La	st)							2. Date of De	eath Day	y Year	3. Time of Death
	Physici		Oscar E. Brown								MAY	0.3		01:03 M
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number	r)		4b. City,	Town, or	Location of	Death		4c.	County of Dea	ıth
	LAGIIII		Peninsula legione	al Medica	1/0	stor	<	Sali	strice	/			Wicom	100
	Funeral		5. Social Security Number 6. S		ige (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2	4 Hrs. Min.	8. Date of Bit	rth	Q Ri	rthplace (State or Foreign country)
	Director		219-03-5871	MM 2□F	84	Yrs.	MOTILIS	Days	Houis	PVIIII.	3-2-19	21		MD.
	ō.		Usual Residence of Decedent		1									T
	how	_	10a. State 10b. County			y, Town or Lo								10d. Inside City Limits
	e-fs	cto	Md. Wicomi	.co	F	ittsvi	lle							1 ☐ Yes 2 X No
	or 28	ire	10e. Street and Number				10f. Zip	Code				-	izen of What C	ountry?
	th wi	al	7996 Pittsville	Road						850		US		
	within 72 hours after death with the Maryland ene. than 'naturel', or Itams 23a or 28e-f show to Madical Examiner and be natified at	by Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U ?	.S. 13.	Was Deced	dent of Hi	ispanic Orig ın, Mexican,	in? (Spe , Puerto l	cify Yes or No Rican, etc.)	D-	14. Race - Am Black, Whi	
9	or It	F.	1 Never Married 2X Married	1 X Yes 2 [	]No		1 🗆 Yes						Specify: Wh:	ita
8	urel',	d b	3 Widowed 4 Divorced	If Yes, Give Year or Dates	WWII									
21215-0036	72 h	Completed	15. Decedent's E (Specify only highest gr			16a. Dece (Give	kind of wo	rk done d	during most	of worki	ng	16b. K	ind of Business	s/Industry
2	dithin	ldm	Elementary/Secondary (0-12)	College (1-4o	r 5+)	1	DO NOT us		•			Do ol	coo Ct	220
N	ygier ygier ygier ygier ygier		17. Father's Name (First, Middle, Last	<u> </u>		Owner	:/Opei	rato		r'a Nama	(First, Middle		age St	)[e
Maryland	2 should be filed within and Mental Hygiene. Is marked othar than aumatic avant, It e M.	Be											Sumame	
yla	Men Men arke	ို	Clarence E. Brov			T		l			vell Br			7.0.11
Jar	2 sh and Is m		19a. Informant's Name/Relationship				•						or Town, State,	ZIp Code)
	1 and 2 Health tam 27		R. Bryce Brown,	Son	205 5				ı. Dov		DE. 19		ocation - City o	Town State
Ore	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If itam 27 is marked other than "naturel", or itams 23a or 28e-f show or other traumatic event, if a Madical Examiner must be natified at		20a. Method of Disposition  1X☐ Burial 2 ☐ Cremation 3 ☐	Removal from Stat	е с	Place of Dispo semetery, crea	matory or o	ther plac	1 .		_			
Ξ	Part ary		`4 □ Donation 5 □ Other (Special	<b>ý</b> )	St.	Steph				-6-0	)	De	lmar,	De.
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If itam 27 any injury or other tr. <u>QDGB</u> .		21. Signature of Funeral Service Lice	nsee		22	Name an	d Addres	ss of Facility eral F	lome				
_	90 = 90		Tigueles				3 E.	Grov	ve St.	De.	Lmar, I		9940	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that cause one cause on each	ed the deat line.	h. Do not en	er the mod	e of dyin	g, such as o	cardiac o	r respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(as	na	10	ando	24 0	~	De	e one	_		Onset and Death
	/Medical		resulting in death)	Due to (or e	is a conseq	yence of):		$\rightarrow$						
	Examiner		Conventially list conditions	h Hy	Re	· fer	- 4	2	/					rear-
	ايراك	ner	if any, leading to immediate	Due to for a	a consed	uence of):								
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c										
o,	an ar	EX	resulting in death) Last	Due to (or a	is a conseq	uence of):								
8760,	ate be ex hysician the buria	dlcal		d										
9	tiffica ng ph as tr	led												
Вох	death certifics attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1□Live birth			∃Ectopic pr	eanancy					23d. Date of de	
	deat e attr	ICIS	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant 9☐Unknown	at time of d		Other (sp						Month	Day Year
P.0	that the de led by the a detached f	hys	9 Unknown	9LI UNKNOWN										
	igned be det		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying o	ause give	en in Part I.		23e. Did	tobacco i		to the cause of death?
rds	w require been sig should b	pa pa									1 🗆	Yes 2	ŪHNo 3□P	Probably 4 Unknown
Records,	s been should	olete									24a. Was		24b. Were a	utopsy findings available
Re	The lav ate has page 2	Completed by										omed?	death?	completion of cause of s 2 □ No
a	i <b>cian</b> : Th certificate rector, pag	Ö	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	2410	1010	5 2 110
of Vital	Physician: r this certific ral director,	0	examiner?	Hospital: 1 ☐ Inpa	tiont 2	ER/Outpatie	nt 3 DC	Oth	057				6 ☐Other (Spi	acifu)
of	Phys rathis	- To	27. Manner of Death	28a. Date of In	ijury	28b. Time o		8c. Injun Wor			28d. Describe			sciry/
O	ding I	tlon	1 ☑Natural 5 ☐ Pending	(Month, E	Day Year)	Injury	м		k? Yes 2⊡N	No				
S	vttendi death. ctor: A y the fu	ica	3 ☐ Suicide 6 ☐ Could not b	De Blace of I	niury - At h	ome, farm, st	reet, factor	v. office						Rural Route Number,
Division	after death Director:	Certification:	4 Homicide determined	building,	etc. (Specil	(y)		,			City or To	wn, State	9)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying P	nysician: To the be	et of my kno	wiedne deat	h accurred	at the tin	ne date and	d place :	and due to the	cause(s	and manner a	s stated
	Hos 24 ho Fun fely	Medical	(Check only 2 Medical Exa	miner: On the basis and manner	of examina	ation and/or in	vestigation	, in my o	pinion, deat	h occurr	ed at the time,	date and	d place, and du	e to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	/)	statoo.		290	c. Licens	e number			29d. Da	te signed (Mor	oth, Day, Year)
	¥ 3 7 8		MA 11	1/				0	7 8	70	9	<	7.7	
7			///////	1000			D. in it	/ (	2/	7			1 0/00	
			30. Name and address of person who						010	0.1				
			Dr. Wm. Robins,						. 218	01				
	- Sta	ate rar	MAY 0 6	2005	20,20	ature /	marke	1						

			For State Registrar	State of Maryland /	-	rtment of H		nd Mental	Hygier Reg.		15934
			Decedent's Name (First, Middle, Last)					2. Date of		Day Year	3. Time of Death
	Physici: /Medic	al -	ROSLYN	BLOOM				MAY 2			12:11 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or		Death		4c. County of Death	
Ī	Funeral Director		SHADY GROVE ADVENT 5. Social Security Number 6. Sex 122-03-3182			ROCKVILL If Under 1 Year Months Days		Hrs. 8. Date of (Month		ar)   Cou	place (State or Foreign untry)
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	wn or Loc	cation	-				10d. Inside City Limits
	within 72 hours after death with the Maryland liene. Than "natural", or Items 23s or 28s-f show the Medical Eraminer must be notified at	tor	MARYLAND MONTGOMER	Y ROCKVI	LLE						1X Yes 2 □ No
	r 28a	Directo	10e. Street and Number	1 KOCKVI	خليانا	10f. Zip Code			10g.	Citizen of What Cor	untry?
	th wit	al D	1801 E. JEFFERSON	ST., APT. 441			852			U.S.A.	
	er des Items	Funeral	11. Marital States	<ol> <li>Was Decedent Ever in U.S. Armed Forces?</li> <li>Yes 2 MNo</li> </ol>	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origi an, Mexican,	n? (Specify Yes of Puerto Rican, etc	or No- :.)	14. Race - Amer Black, White	
35	irs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:			Specify: WH	ITE
5-0036	72 hou natura	ted	15. Decedent's Educ (Specify only highest grade		a. Deced	lent's Usual Occup	ation during most o	of working	16b	. Kind of Business/I	ndustry
	ithin 7 ner Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	OO NOT use retired	d) -			DIWAME OF	стор
22	a filed within Il Hygiene. other than "	Col	12   17. Father's Name (First, Middle, Last)	JU	NIOR	ACCOUNT		s Name (First, M		RIVATE SE	CTOR
Maryland	9 1 5 5 ×	To Be	ISADORE	ZALEON			CLARA	KROS	SSOV		
ary	es 1 and 2 should be of Health and Mental I Item 27 is marked or other traumatic even	۲	19a. Informant's Name/Relationship (Typ	pe, Print) 19	b. Mailin	g Address (Street	and Number	or Rural Route N	lumber, Ci	ty or Town, State, Z	ip Code)
	and 2 eaith a n 27 is		JUSTIN BLOOM/HUSBA				SON ST			VILLE, MD	
Baltimore,	T ite		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 X Re	emoval from State	ery, cren	sition (Name of natory or other plac	,	Date		. Location - City or	
<u>=</u>	t. Pag rtmen rtant:		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>			The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon					H, VIRGINIA
e B	permit. Pages Depintment of I Important: If its any injury or o		21. Signature of Funeral Service Eldense	Itottlemuer	DÂ	NZANSKY- 70. ROCKV	GOLDBE TIJE P	RG MEMOR	RIAL	CHAPELS, LE, MD 20	INC.
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on		not ente	er the mode of dyin	ng, such as ca	ardiac or respirat	ory arrest,	BB, 115 20	Approximate Interval Between
IJ,	Pnysician		Immediate Cause (Final disease or condition	Dunet mohi		Cardio	my no	athe			Onset and Death
	/Medical		resulting in death)	Due to for as a consequence	e of):			1			- y civ. ,
	Examiner		Sequentially list conditions, b	Due to (or as a consequence	ni c	2					2 days
	pet lisit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	5 OI).						
Ć,	execunary and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	e of):						
1760	The faw requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the buriat-transit			l							
89	leath certifica attending ph I for use as th	Physician/Medical	IF FEMALE:	G- 16							
Box	es that the death cer igned by the attendin be detached for use	ian/	in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)	4			23d. Date of deli Month	Day Year
o.	y the d	ysic	1 ☐ Yes 2 ØNo 9 ☐ Unknown	9□ Unknown							
s, D	s that ined b e deta	by Pi	Part II. Other significant conditions con	tributing to death but not resulting	in the u	nderlying cause giv	en in Part I.	23e.			the cause of death?
ords	w require been sig should b								1 🗌 Yes	2 <b>1</b> No 3 □ Pr	obably 4 Unknown
Record	e taw re has be ye 2 sh	Completed						24a.	Was an autopsy performed	prior to o	topsy findings available completion of cause of
<u> </u>		Con						10	Yes 2	1 ☐ Yes	2□ No
<u> </u>	ysician: Th is certificate director, pag	Be.	25. Was case referred to medical examiner?	lospital:	Sutmation	nt 3 DOA		of Death (Check		e 6 ☐Other (Spec	niful.
o	Attanding Physician: r death. sctor: After this certifica	n; To	27. Manner of Death		. Time of		ry at			njury occurred	ary)
ion	ath. ath. r: After ne funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Worter, Day 1 dar)	Injury		Yes 2□N	lo			
Division of Vital	for Attancater death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Loca City	tion ( <i>Str</i> ee or Town, S	t and Number or Ru tate)	iral Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phys	sician: To the best of my knowled	ce death	h occurred at the ti	me date and	I place, and due t	o the caus	e(s) and manner as	stated.
	To the Hospital within 24 hours a To tha Funeral I completely filled	edical	(Check only 2 Medical Examinations)	ner: On the basis of examination a and manner stated.	and/or in	vestigation, in my	opinion, death	h occurred at the	time, date	and place, and due	to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier			29c. Licens	se number			Date signed (Monti	
ŀ	10						817		M	xy 2,20	05
	t		30. Name and address of person who co		1		Centa	r Dr Po	ckvi1	lle,Md. 20	0850
	Sta	ato	Shahyar M. Gha 31. Date filed (Month, Day, Year)	3. Registrar's Signature	7701	Medical	Cente	I DI. RO	CIVVII		
	Regist		31. Date filed (Month, Day, Year) MAY 0 5 200	5 Beneur B.	A PORTOR OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF TH						

			1- State of Maryland / Department of Health a Certificate of Death			ene 0 0 5	16935
	Dhysisi		1. Decedent's Name (First, Middle, Last)	2.	. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Naomi Bach		ay 3	1	9:25 A. M
1	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location or	of Death		4c. County of Dea	
			Suburban Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2.	24 Hrs.   8.	Date of Birth	Montgon 9. Bi	rthplace (State or Foreign
н	Funeral Director		220-42-4406 1 M 2 F S 93 Yrs. Months Days Hours		Date of Birth (Month, Day, ) March 18	8, 1912	ountry) Maryland
			Usual Residence of Decedent				
	ed at	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	8a-f	ecto	Maryland Montgomery Rockville		100	g. Citizen of What C	X
	with th	Funeral Director	10e. Street and Number  10f. Zip Code		10,		ountry r
	ns 23	era	6111 Montrose Road, # 410 20852  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control of Hispanic Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Origina	igin? (Specif	fy Yes or No-	U. S. A.	
10	riten	Fu	Armed Forces? If Yes, specify Cuban, Mexican	n, Puerto Rio	can, etc.)	Black, Wh	
21215-0036	within 72 hours after death with the Maryland ene. then "returel", or Items 23a or 28a-f ehow the Modical Exam her must be notified a	b	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	: 		Specify: W	nite
2-0	72 h	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	st of working		6b. Kind of Busines	s/Industry
121	vithin ne. hen	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		1	U. S. Gov	ernment
	filed v Hygie other t		1 Year Secretary  17. Father's Name (First, Middle, Last)  18. Mothe	er's Name (	First, Middle, Ma		CIIIIICIIC
Maryland	d a b	To Be		ie Ros	senfeld		
ary	should I	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number	er or Rural F	Route Number, (	City or Town, State,	Zip Code 20814
	and 2 ealth a n 27 le		Elsa B. Carlton - Daughter 10631 Weymouth Str		-		
ore	of He		20a. Method of Disposition  1 Surial 2 Cremation 3 Removal from State	Date	13	Oc. Location - City o	
Ĕ	Pages ment of I		'4 Donation 5 Other (Specify) Mount Lebanon	5/6/20		delphi, M	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: if Item 27 is any injury or other tra- once.		21. Signature of Funeral Service Licensee Danzansky-Gold Be 1170 Rockville	Pike.	Rockvil	lle, Mary	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.	cardiac or r	respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition				Cristiana Stati
	/Medical Examiner	.	resulting in death)  Due to (or as a consequence of):				
١.		70	france leading to immediate b. Due to (or as a consequence of):				
П	uted i inslt	Examiner	Sacuantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
ó	exect an and rial-tra	Exa	resulting in death) Last  Due to (or as a consequence of):				
8760,	sate be executed physician and the burial-transit	icai	d				
9	as as	Physician/Medicai	IF FEMALE:				-t
Вох	that the death cer ed by the attendir detached for use	ian/	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of do Month	elivery Day Year
0.	the a	ysic	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other (specify)   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   1   Yes 2   Yes 2   No 9   Unknown   1   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2   Yes 2				
<u>α</u>	res that the signed by the detaction	H.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1.	23e. Did toba	acco use contribute	to the cause of death?
Records,	luires n sign	d by	Hypartausion Kyphoscoliesis		1 🗆 Yes	2 <b>3 N</b> o 3 ☐ F	robably 4 Unknown
00	w requir s been si should	iete	Hy Dothy M. Alsm		24a. Was an	24b. Were a	utopsy findings available
Re	The law sate has page 2	Completed	OSTROPADOCIC		autopsy performe	ed? death?	completion of cause of
ita		w	25. Was case relerred to medical 26. Place	e of Death (	Check only one,		
of Vital	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nu	ursing Home	5 ☐ Residen	ice 6 □Other (Sp	ecify)
0	Ing Pi		27. Manner of Death  1 Augural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?		d. Describe how	v injury occurred	
Sio	Attending redeath. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		f Location /Stre	eet and Number or F	Rural Route Number,
Division	or At after of Direction by	Certification;	4 Homicide  28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)	201	City or Town,	State)	ibiai i loute i tumboi,
1	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier Physician: To the best of my knowledge, death occurred at the time, date an	nd place, and	d due to the cau	use(s) and manner a	is stated.
	To the Hospital within 24 hours and the Funerel completely filled	edicai	(Check of the part of the basis of examination and/or investigation, in my opinion, deal and manner stated.				
	To the within To the comp	Me	29b. Signature and title olgertified (1) EAP 29c. License number		290	d. Date signed (Mor	oth, Day, Year)
	12		Muy 9 10000 1745839			7/2/07	
			30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	E. RA	DPIT	M.D.	
	Sta	ate	30. Name and address of person who completed cause of death (tem 23a) (Type, Print)  31. Date liled (Month, Day, Year)  MAY 0 5 2005  Registrar's Signature		- 4//		
	Regist		MAY 0 5 2005 Books St. 189				

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Naomi Bach

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8:15 P M **Physician** 2005 Catharine Bartlett 30 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ginger Cove Health Center Anne Arundel Annapolis 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Year) Months 1 M 200 Yrs. 73 233-50-6603 11 1931 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heath and Mentai Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "neturel", or items 23a or 28e-1 show other treumatic event, the Mactical Examilities as 1 ☐ Yes 2 No Annapolis Anne Arundel Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 5206 River Crescent Drive 21401 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William T. Fickinger Elizabeth Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5206 River Crescent Drive Dwight Bartlett/husband Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages Department of Importent: If it eny Injury or o once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Baltimore Crematory 5/2/2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** erelyouas cular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and tran Due to (or as a consequence of): physician a s the burial-Division of Vital Records, P.O. Box 68760, Physiclan/Medical as the attending IF FEMALE: esu. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by should be detact Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 1No or Attending Physicien: 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 3 DOA 2 ER/Outpatient ို Director: After this in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Matural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide the Hospitel 24 hours a Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 0 MD 30. Name and address of person who completed guse of death (Item 23a) (Type, Print) Mighinay Glen Burnic MD 2106/ 08 Crain State Registrar

			1 - For State of Maryland / Dep	artment of Health and Martificate of Death		ene 0 0 5 g. No.	16937
	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death
	/Medic		Deborah E. Bennett		May 2	2005	7:50 and
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Chesapeake Hospice House  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Linthicum  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Anne Aru	place (State or Foreign
	Funeral Director		062-48-7997 1□M 2XIF 49 Yrs.	Months Dave Hours Min	Month, Day, June 18	1955 New	York
	ס		Usual Residence of Decedent				
	arylar show	_	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits  1X Yes 2 ☐ No
	Sa-f	ecto	Maryland Prince George's New Ca	arrollton	10	g. Citizen of What Co	
	a or	Funeral Director	7603 Riverdale Rd. Apt. 422	10f. Zip Code 20784	10	g. Chizen of What Col	•
	leath	eral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - Amer	ican Indian,
(O	r Iter	Fun	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛱 No		Rican, etc.)	Black, White	, etc. Black
ĕ	ral', c	l by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	
5	within 72 hours after death with the Maryland ene. than 'natural', or Items 23e or 28e-f show ite Meulcal Exer'ili er mast be notified at	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation be kind of work done during most of work	ing	6b. Kind of Business/I	-
121	within ane. than '	Idm Idm	Elementary/Secondary (0·12) College (1-4or 5+)	DO NOT use retired)		Departmen	
2	filed Wygie	ပ္ပိ	12th 6 yrs.	Case Worker  18. Mother's Name	e (First, Middle, M.	Social Se aiden Sumame)	rvices
aŭ	Mental Mental arked o	To Be	Raymond Bennett	Olive	Armstr	cong	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Iften 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. The Medical Exar' if is irrais Lie notified at	-		ing Address (Street and Number or Run			ip Code)
	コニトサ		Phillip Bennett (Son) 2555	Ashley Oak Dr.	Schert	z, Texas	78154
ore	of He of He fitem roth		20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obstacle 20b. Place Obsta	osition (Name of matory or other place)	Date 2	Oc. Location - City or 1	own, State
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Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.			2. Name and Address of Facility 82	21 West	St. Anna	polis, Md.
	402 e Q		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	Vm. Reese & Sons			21401 Approximate
			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  SEPSLS	nor the mode of dying, but a but did o	or roophatory arrow		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):				
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying				
	ecuted ind transi	Examiner	that initiated events c.				
760,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
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×	death certific attending plater use as i	υ/Μ¢	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	76		23d. Date of deliv	very
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ord	w require been signationships	ted			1 ☐ Yes		
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o	Attending For death.  ector: After by the funera	atlo	2 Accident investigation	M 1 Yes 2 No			
N		Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
	oital or urs afte oral Dir illed in						·
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) Certifying Physician: To the besign finy knowledge, deal (Check only one) and manney stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cau red at the time, dat	e and place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	Day, Year)
)	->-0		Mudaten.	1)004174	7	5 3	2005
			30. Name and address of person who completed cause of death (Item 23a) (Type	Print	11	4	- 3 -
			MAKIO Nictolson, MD 6525	Belcrest Rom	p, Hyall	suille, N	10 20782
	Sta Registr		31. Date filed (Month, Day, Year)  MAY () 4 2001	Snorth )	. /	-	
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	1- State Unpend Item 23	a-b&2/ per me Go24	rtificate of Death		No. UUD	16938
Physician	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
/Medical	Brent James Bake			1 2 -		0940 P M
Examiner	4a. Facility Name (If not institution, give stre Frederick Memorial		4b. City, Town, or Location of Death Frederick	1	4c. County of Death Frederick	
- Courterly	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth		ce (State or Foreign
Funeral Director		34 Yrs.	Months Days Hours Min.	October 1,	1970 Maryla	and
yland	10a Chata 10h County	10c. City, Town or L			100	d. Inside City Limits
8a-f st	Maryland Frederick	Brunswic		10-	Citizen of Miles County	1 X Yes 2 □ No
death with the Maryland ms 23a or 28a-f show trinist be notified at neral Director	707 N. Maple Avenue		10f. Zip Code 21716	109.	. Citizen of What Country U.S.A.	y r
ems ems	11. Marital Status	. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- Dican, etc.)	14. Race - American Black, White, et	
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nd 2121 e filed within al Hygiene. tother than " vent, Ile Me	17. Father's Name (First, Middle, Last)	пстр		ne (First, Middle, Mai		
tore, Maryland 21215-0036  ges 1 and 2 should be filed within 72 hours after death with the Marylan to of Health Mental Hygiene it in fem 27 la marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinant the notified at To Be Completed by Funeral Director	James Collins Baker		Clara	Jane Sirk		
Mar nd 2 sho ulth and 27 la m r traum	19a. Informant's Name/Relationship (Type Cherie Baker – wife		ling Address ( <i>Street and Number or Ru</i> N. <b>Maple, Brunswic</b>	ral Route Number, C <b>k, Maryla</b> i	ity or Town, State, Zip C ad 21716	code)
Baltimore, M permit. Pages 1 and 2 pepartment of Health important: if item 27 any injury or other truence.	20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ Ren		position (Name of ematory or other place)  e Cemetery 5/14/	The second second	c. Location - City or Town	
altim mit. Pa partmer portant r injury	*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	0,0	22. Name and Address of Facility	tauffer Fu	uneral Home	
Bal permi Depar Impo any ir	Sharow Camel	V 4 7 - 1 - 1	100 N. Maple Avenu			nd 21716
	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	tions that caused the death. Do not el cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	, A II	Approximate nterval Between Onset and Death
Pnysician /Medical	disease or condition resulting in death)	Cardiac Arrhythmia  Due to (or as a consequence of):	1			<u> </u>
Examiner 5	Sequentially list conditions, and any, leading to immediate	Mitral Valve Prola	apse and Cardiomeg	aly		
60, be executed ician and burial-transit	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
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ox 68" or certificat anding phy use as th	IF FEMALE: 23c	. If yes, outcome of pregnancy			23d. Date of delivery	
. o o o	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		☐ Ectopic pregnancy ☐ Other (specify)		,	ay Year
	Part II. Other significant conditions contri	buting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	cause of death?
Records, P he law requires that he has been signed to age 2 should be deter				1 ☐ Yes	2 No 3 Probab	oly 4 Unknown
al Record The law requir cate has been s page 2 should				24a. Was an	24b. Were autops	y findings available
The law ate has page 2.5				autopsy performed	d?   death?	oletion of cause of
f Vital F ysician: Th is certificate director, pag	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)		
of Vita	1 X Yes 2 No Hos	spital: 1 ☐ Inpatient 2 🗵 ER/Outpatie			e 6 Other (Specify)	
ing P After t unera lon;	27. Manner of Death  1X Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	injury occurred	
Division  Tor Attending after death. Director: After tin by the fune or tification.	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	28f Location (Stree	et and Number or Rural F	Route Number
Division of the or attending P rs after death. Tall Director: After ted in by the funerated in by the funerated certification;	4 Homicide determined	building, etc. (Specify)	Riest, factory, office	City or Town, S		10010
Hosp 14 hour Funer tely fill		eien: To the best of my knowledge, dea r: On the basis of examination and/or i				
To the within 2 To the complet	29b. Signature and title of certifier	and manner stated.	29c. License number	29d.	Date signed (Month, De	ay, Year)
F 3 F 8	Pot () no	m. 14 - Kallona	OCME	May	y 11, 2005	
	30. Name and address of person who com	pleted cause of death (Item 23a) (Type	a. Print) 111 Penn Street	Baltimore	Maryland 3	21201
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1	Juliore,	raryrand 2	-14VI
Registrar	MAY 1 6 20	US Alexander St.				

			1 - For State Registrar	State of Maryla		artment of Health an <i>rtificate of Death</i>		giene Reg. No. 0	15 16939
			Decedent's Name (First, Middle, La	st)			2. Date of De Month		3. Time of Death
	.Physici /Medic			Mildred Pa	uline B	ason	May		005 8:45 A <sup>M</sup>
-	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Location of E		4c. County o	
			4814 Hale Haven I			Ellicott Cit			oward
	Funeral Director		213 32 0516	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year   If Under 24   Months   Days   Hours	Min. (Month, Da	th. Year) 5, 1918	9. Birthplece (State or Foreign Country) South Carolina
	and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation			10d. Inside City Limits
	Manyl f eho	ō	MD Howard	3	Elli∞t	t City			1 ☐ Yes 2 ☐ No
	28a	Director	10e. Street and Number	4		10f. Zip Code		10g. Citizen of W	hat Country?
	3a of	<u></u>	4814 Hale Haven I	Orive		21043		United	d States
	72 hours efter death with the Maryland natural', or Itame 23a or 28e-f ehow draal Exeminer rust be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No Juerto Rican, etc.)	- 14. Race Black	- American Indian, k, White, etc.
9	or Its	Fu	1 Never Married 2 Married	1 ☐ Yes 2 2No If Yes, Give		1 ☐ Yes 2 XNo Specify:		Specify:	
8	uraf',	d by	3 Widowed 4 Divorced	Year or Dates:	1 10: 5			40h Kind of Bus	White
21215-0036	"net	Completed	15. Decedent's E- (Specify only highest gra		/Give	ident's Usual Occupation is kind of work done during most of DO NOT use retired)	f working	16b. Kind of Bus	siness/industry
12	within iene.	шc	Elementary/Secondary (0-12)	College (1-4or 5+)	Assi	stant Manager		Bankir	ng
	illed Hygi other	0	17. Father's Name (First, Middle, Last,	)		18. Mother's	Name (First, Middle	, Maiden Surname	<del>)</del>
lan	dental dental rkad c	To Be	Carl Garrison			Iva A	dams		
Maryland	2 should and Men is marks sumatic		19a. Informant's Name/Relationship (	Type, Print)		ing Address (Street and Number of		-	
	end 2 ealth n 27		Carol J. Fincham		_	Hale Haven Dri			
ore	Pages 1 nent of He int: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	D	cemetery, cre	osition (Name of matory or other place)	Date		City or Town, State
altimore,	tment tant:		*4 □Donation 5 □ Other (Specif			wn Mem. Gard. 5			tsville, MD
Bai	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or itame 23e or 28e-f ehow any injury or other traumatic event, the Medical Examiner rotal be notified at one.		21. Signature of Funeral Service-Licer	S - W MO	1044   2	2. Name and Address of Facility 112 Old Columbi	larry H. W: a Pike El	itzke's I licott C	Family FH Inc. ity, MD 21043
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that daused the doone cause on each line.	1	ter the mode of dying, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner			b Lunba	equence of):	Compression	n fra	cture	o Imente
4	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):	0515			Years
Ć.	execunand nandial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a cons			· - /	- 4 1	
8760,	cate be executed oblysician and the burial-transit	icai		d. Po	3/6	CALCIUN	1 1.0	TAKE	year)
9	entific ding p	Med	IF FEMALE:	23c. If yes, outcome of pre-	ananav			004 Oate	- A deliver
S. Box	it the death certifica by the attending pt tached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopic pregnancy □ Other (specify)		Mon	e of delivery hth Day Year
s, P.O.	signed by d be detacl	by Phy	Part II. Other significant conditions					_/	ibute to the cause of death?
ord	w requir been si should	ted	CERTOROL	ascular	-00.44	ease	11	Yes 2 ☑No	3 Probably 4 Unknown
l Records,	The lan	Completed	Itig a be	lood pre	SSUN	2		psy pr prmed? de	Vere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2Ⅸ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				Death (Check only o	one)	
7	hysic his co	ုင္	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2			ng Home 5 XResi		
Ĕ	ing P	-Co	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	1 1 1 1 1	Work?		how injury occurre	,
Division of	ttend death stor: /	Certification:	2 Accident investigatio 3 Suicide 6 Could not b	LLOV PILLOU				Street and Number	or or Rural Route Number,
<u>&gt;</u>	or A after Direction by	artif	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)	neer, ractory, onice	City or To	wn, State)	To more more management
_	To the Hospital or Attending Physician: The witin 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Cartifying Pt			th occurred at the time, date and p	place, and due to the	cause(s) and man	nner as stated.
	P Fur	edical				nvestigation, in my opinion, death			
	To th To th comp	Me	29b. Signature and title of certifier	n n		29c. License number	-		(Month, Day, Year)
)			> Releve	Villelon	W	D3157	)	May 5,	
			30. Name and address of person who	completed cause of death (I	tem 23a) (Type	Print)	2. 11 D:	Clara a	2 Ell cord City NA
			KANA KOLCO	22 Parished S	(I)	1001 UID HN	nevill Ka	. JTP. 20.	2 21011
9	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sig	griature P#		-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1tem 20b per Th 2845 7-21-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** May 6, 2005 Neva Grace Cook /Medical 7:00 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 407 Main Street Mardela Springs Wicomico If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🎛 F Yrs **Director** 517-09-2379 89 14,1916 South Dakota February Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ahow item 27 is marked other than "natural", or items 23a or 28a-f ahor other traumatic event. The Medical Examinat must be notified at 1 TYYes 2 No Director Wicomico Mardela Springs 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 407 Main Street 21837 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Beautician <u>The Hacienda House</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Burr T. Barnes Mamie Nichols 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other place)

April 20c. Location · City or Town, State Judy A. Lucas/Daughter
20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from State 5-6-2005 ö \* 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Salisbury Crematory 22. Name and Address of Facility
Holloway Funeral Home Professional Association Signature of Funeral Service Licensee any i Javie 34 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd. Salisbury, MD 21804 Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCUD /Medical Due to (or as a consequence of): Examiner Penenha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit and resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 Tyes 2 □ No 3 Probably 4 ☐Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2□ No 1 ☐ Yes 2 ☑ No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 Tes this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after death uneral Director: 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Thomicide 24 hours a pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 576/00 NAB 147094

Registrar DHMH 17 Rev 1/2001

State

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

or Attending

Hospital

the

Division of Vital Records, P.O. Box 68760,

1415 S. Division St., Suite B, Salisbury, MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

Vel

MAY 0

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 28 2005 9:30 AM Hugh Dorsey Chandler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 4307 Hartford Hills Drive Marlow Heights If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 12XM 2□ F Director 6, Georgia 579-40-0477 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or than "natural", or items 23a or 28a-f show the Wedical Exemities must be notified at 1 ☐ Yes 2 ☐ No Directo Marlow Heights Maryland | Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20746 United States 4307 Hartford Hills Drive death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Black Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Transportation Specialist Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itam 27 is marked oth any jury or othar traumatic avant 2008. Be Foster Chandler Charity McMillan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4307 Hartford Hills Drive, Marlow Hgts., MD 20746 Clara L. Chandler - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5/31/2005 Arlington, VA Arlington National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4001 Benning Rd., N.E. Wash., DC 20019 Approximate Interval Between Onset and Death **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a nonescuarios or): Examiner The law requires that the death certificate be executed DIABETES and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Completed by Physician/Medical the use as guipo IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ō in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached Division of Vital Records, P.O. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 1 🗌 Yes 2 XNo 1 Tyes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 XNo 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification; Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) p 4 Homicide filled in within 24 hours a 🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To tha I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0054344 MAY 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELISSA TURNER, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2. Registrar's Signature

State

MAY 96

				State of Maryl	and / Dep		f Health a	and Me	ental Hyg	iene	05	16942
			Decedent's Name (First, Middle, Last)					2	2. Date of Deat			3. Time of Death
	Physicia /Medic	al	RALIE BELL COLLI  4a. Fecility Name (If not institution, give s			4h City Tow	m, or Location of	of Deeth	Month MAY	04, 4c. C	2005	9:15A M
	Examin	er			ALTERNA TO							GEORGES
_			PRINCE GEORGES F  5. Social Security Number 6. Sex		NTER yrs. last birthday)	1471	HEVERLY		8. Date of Birth (Month, Day			hplace (State or Foreign untry)
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•	and and		10a. State 10b. County	100	c. City, Town or L	ocation						10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	ŏ	MARYLAND PRINCE G	OPCES I.	ANDOVER							XX Yes 2 □ No
	288-	Director	10e. Street and Number	ORGED II	IIIIDO V LIIC	10f. Zip Co	de		1	0g. Citiz	en of What Co	untry?
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	0 ath	era	7018 EAST CHESAPEAR	2. Was Decedent Ever	in U.S.   13.	Was Decedent	of Hispanic Ori Cuban, Mexican	igin? (Spec	ify Yes or No-		4. Rece - Ame	ncan Indian,
	riten	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes XX No					ican, etc.)		Black, White	
Š	o'.'e	þ	3XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2102	No Specify:				Specify: BL	ACK
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<u>0</u>		To	JAMES BLACK				ANNI	E HAR	PS			
ary	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mail	ing Address (Si	treet and Numbe	er or Rural				
Σ	and 2 ealth an 27 i		JACOB COLLINGTON /	SON	5905	BURGU	NDY STRI					, MD 20743
Ē	iter of		20a. Method of Disposition  XIX Burial 2 ☐ Cremation 3 ☐ R		<ol> <li>Place of Disp cemetery, cre</li> </ol>	osition (Name of ematory or other	of r place)	Da	ate	20c. Loc	ation - City or	Town, State
baitimore,	permit. Pages Department of Important: If it eny injury or o	١.	`4 □Donation 5 □Other (Specify)	emoval from State	CEDAR HI	LL CEMI	TERY (	05/14	/2005	S	UITLAN	D, MD
	mit.		21. Signal re of Funeral Service License	00	2	2. Name and A	ddress of Facili	ity E.R.AT.	HOME OF	' MAR	YI.AND.	INC.
ñ	8 8 E 8 8		). Mays	hell_	1 4	308 SU	ITLAND I	ROAD	SUITL	AND,	MD 20	746
	Physician		23a. Panh Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the e cause on each line.  RENAL FAI		nter the mode o	f dying, such as	s cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death 5 MONTHS
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ROX	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death 3	☐Ectopic pregi				2	3d. Date of de Month	Day Year
- -	the a	Sic	1 ☐ Yes 2XXVo 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown	e of death 5	Other (speci	Ty)					
J.	that the di ed by the detached	Phy	Part II. Other significant conditions con	stribution to death but no	ot resulting in the	underlying caus	se given in Part	1.	23e. Did to	bacco u	se contribute to	o the cause of death?
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Division of Vital Records,	w requir been si should	sted					,		04: 146-			
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Ĕ	ding P. After funera	on:	27. Manner of Death  1XXNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye			. Injury at Work? 1 ☐ Yes 2 ☐	1	.bu. Describe i	iow injury	, 00001100	
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$\overline{\leq}$	or Attendate death Director:	E	4 Homicide determined	building, etc. (5	Specify)	street, ractory, c	mice		City or Tov			
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier XX Certifying Phy	sician: To the best of m	w knowledge de	ath occurred of	the time date a	and place is	and due to the	cause/e\	and manner a	s stated.
	Hospital 24 hours a Funeral stely filled	edicai	(Check only one)	ner: On the basis of ex and manner stated	amination and/or	investigation, in	my opinion, de	ath occurre	ed at the time,	date and	place, and du	e to the cause(s)
	To the within 2 To the comple	Mec	and Simple and title 64 metrics			29c. l	icense number		110		e signed (Mon	
	To		W.K	worky	7	01	622	-3	MA	5	74/0	25
.5	00		30. Name and address of person who c	ompleted cause of double	h (Item 23a) (Tyn	e. Print)					-	
(	YU		R. MURTHY, M.D.	opictos causo of coat		LANDOVE	R ROAD	CF	HEVERLY	, MD		
	Si	tate	31. Date filed (Month, Day, Year)	39. Registrar's	Signature							
	Regist		MAY 0 6 2005	France	# 60	and a						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2005 **Physician** April William John Chadwick 30, 11:56 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 12/14/1925 Birthplace (State or Foreign Country) **Funeral** 1 XM 2 F Director 79 Maryland 219-10-2107 Usual Residence of Decedent perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental: Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinations or other traumatic event, the Medical Examinations. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12006 Long Ridge Lane 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: 42-46 1 ☐ Never Married 2 🔀 Married Specify: White 1 ☐ Yes 2 XNo þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Claims Supervisor Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 William J. Chadwick Elizabeth Wight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Chadwick/ Wife 12006 Long Ridge Lane Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 5/4/2005 Huntt Crematory Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sentic Shreh **Physician** /Medical Due to (or as a consequence of): Examiner Metenteric Luline Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by Respiratory toulune 1 Yes 2 No 3 Probably 4 Unknown Prenuonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 No 2 🗆 No director, 25. Was case referred to medical 26. Place of Death Check on one 1 XYes 2 □ No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati To the Funerel Director: completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 3 05 velolbech, orb D 46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Siving Bech, WD 2001 Wedical landway bird Bech, MD , anna polis, MD 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature State MAY 0 3 2005 Registrar

			1 - For State Registrar	State o	f Marylar	-		t of H	ealth a		ental Hy	giene Reg. No	UUJ	16944
	Dhyoia	ion	1. Decedent's Name (First, Midd	tle, Last)							2. Date of De Month	ath Da	y Year	3. Time of Death
	Physic /Medi		Esther V.				,				April		2005	12:36 a <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution		,		4b. City,	Town, or	Location of	of Death		4c.	County of Dea	th
H			Anne Arundel  5. Social Security Number	Medical 6.Sex	Cente 7. Age (In yrs.			apo:	lis If Under:	24 Hrs. L	0. D. M. (1.0)		ne Ar	
	Funeral Director		217-26-6387	1 M 2 T F	7. Age (117 yrs.	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da ay 31	y, Year)	9. 81	thplace (State or Foreign ountry)
			Usual Residence of Decedent							1710	ay 31	192	29 Mai	yland
	arylan show	-	10a. State 10b. Count	У	10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	8e-f	cto	Maryland Anne	Arunde1	An	napol								tyE Yes 2 □ No
	with the	Dir	10e. Street and Number				10f. Zip					10g. Cit	izen of What C	ountry?
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"	fter d	Funeral Director	1 □ Never Married 2 □ Ma	Armed Fo	rces?	13.	If Yes, spec	rfy Cubar	n, Mexican	, Puerto R	cify Yes or No lican, etc.)		14. Race - Ame Black, Whi	
036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f ehow afted Exercit et Frust be routified at	by	3 XWidowed 4 ☐ Divorce	If Yes Gi	/e		1□Yes 2	No No	Specify:				Specify:	Black
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and	ould be f Mental I arked of	Be C	Thomas Br	,							an Hai		Sumame)	
Maryland	2 should and Men la marke eumetic	7	19a. Informant's Name/Relation			19b. Mailir	na Address	(Street a					r Town, State.	Zin Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28e-f show tiem 27 is marked other then "natural", or Items 23e or 28e-f show other treumstic event, if a Modical Extraction at its and be rutified at		Barbara Smit		ter)								2140	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 la eny injury or other tret once.	-	20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	ne of		Da			cation - City or	
E	Page nent c ant: If		1 🖾 Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (-		State FOW Com	remetery crej ler U leterv	,М,	Chui	ch¦ ,	5/7/(	05	\nn=	polis	Md
alti	permit. Departn Importe any inju		21. Signature of Funeral Service	Licensee	COL	22	2. Name and	d Addres	s of Facility	v				
_	20 E 2 9		Larry 1.	Reaso Ma		8	21 W	est	St.	Anna	apolis	3. N	, P.A Id. 21	401
В			23a. Part1. Enter the disease, of shock, or hear failure. Lis	r mplications that c t onty one cause on e	aused the deat ae.	h. Do not ent	er the mode	e of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a.	Caro	liac	A	nv	lkn	19				Onset and Death
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		io i	Sequentially list conditions,	b. — Due 10 l	or as a conseq	uence of:								
	uted d ansit	Examiner	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>`</b>		,,.								
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Вох	eath certific attending p I for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	I death 3	Ectopic pre	gnancy				1 2	23d. Date of del Month	,
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Ξ	or Atten after deat Director: in by the	ij	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ninga 286 Place	of Injury - At ho	ome, farm, str	eet, factory,	office		28	f. Location (S City or Tow			iral Route Number,
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	To the Hospital or Attent within 24 hours after deall To the Funeral Director: completely filled in by the	edical	29a. Certifier Certifyi (Check only one) Medical	ng Physician: To the Examiner: On the ba and mann	isis of examina	wledge, death tion and/or inv	occurred a restigation,	it the time in my opi	e, date and inion, deatl	d place, and h occurred	d due to the d at the time, d	ause(s) date and	and manner as place, and due	stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Year **Physician** AUANAUGH 7.50 PM FRANCIS APRIC 2005 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner MOUNT AIRY LIVING -ORIEN ASSISTED CAPROGE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** 1 MM 2□ F Director 160-12-282 Usuel Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? b Peges 1 and 2 should be filed within 72 hours aftar death with USA AUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M.Yes 2 No If Yes, Give Year or Dates: 17 43 - 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) end Mental Hygiena. ADVECTISING 12 SALESMAN ADVERTISING 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CAJANAJEH KATHERINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) CAUANAUGH CROSSING; AURENCEVILLE, GA 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State MAY 2 1 Burial 2 □ Cremation 3 A Removal from State WEST DEUTON CEMETERY 4 Donetion 5 Dother (Specify) 22. Name and Address of Facility
J. WILLIAM MCCAULEY JR. FUNERAL HOME, INC. 21. Signature of Foneral Service Licensee 901 VINE STREET, WEST NEWTON, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 10 YEARS Examiner Examiner sician end buriel-transit The law requires that the daath certificata be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or es e consequence of) Box 68760 physician Physician/Medical the the Due to (or as e consequence of) ed by the attending p datached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? ART HRITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? eral Director: After this cartificate has filled in by the funeral director, page 2: 2 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2₽ No Certification: To 1 Yes 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Netural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinating end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Yeer) JULIO MENOCAL, M.D. -31912 105/0 V Juno 30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

PILLE

Opossumtown

2005

31. Date filed (Month, Day, Year)

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			1- State of Maryla		artment of H			ene 2005	16946
			1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		EUNICE BROWN CUPPLES				MAY 9,	2005	9:05 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De	ath	4c. County of Death	
			GENESIS LA PLATA CENTER		LA PI			CHARLI	
	Funeral		1UM 2AIE	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		(ear) 9. Birthp	place (State or Foreign htry)
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	yland		10a. State 10b. County 10c.	City, Town or Lo	cation			1	IOd. Inside City Limits
	B Mari	Funeral Director	MARYLAND CHARLES	LA PLAT	`A				XXYes 2□No
	or 28	Jire	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cour	ntry?
	ath w	rai	1 MAGNOLIA DRIVE		2064			U.S.A.	
	er de Items	nue	11. Marital Status  12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	
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21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. of other than "natural", or Items 23a or 28a-1 show evant, the Medical Evanimer must be notified at		15. Decedent's Education	16a. Decec	dent's Usual Occupa	ation	10	Sb. Kind of Business/In	
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nd	be file	Be	17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middle, Ma	aiden Sumame)	1.2
Maryland	should be nd Menta i marked umatic ev	2	JULIUS LEE BROWN				SESSIONS		
Mar	l 2 sho		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zip	
	s 1 and 2 should f Health and Men item 27 ls marke othar traumatic		TRISH WATHEN-DAUGHTER  20a. Method of Disposition 20b	3680 D. Place of Dispos		LAKELA	AND DR., M	ECHANICS\	VILLE, MD Dwn, State 2065
Baltimore,	00		1  ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren	natory`or other plac				
量	permit. Pag Depertment Important: I any injury o		'4 □ Donation 5 □ Other (Specify) TRITE  21. Signature of Funeral Service Licensee MOO479		MORTAL  Name and Addres		5-12-05	WALDORE/A	MARYLAND
Ba	permit. I Depertm Importar any injui		M004/9				RAL SERVI	CE, PA	
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	To tha Hos within 24 ha To the Fun completely	edical	(Check only 2 Medical Examiner: On the basis of examone) and manner stated.	ination and/or inv	vestigation, in my o	pinion, death oc	ccurred at the time, dat	e and place, and due to	the cause(s)
	To tha within 2. To the I complet	Σ	29b. Signature and title of certifier	• • •	29c. License	e number	296	d. Date signed (Month,	Day, Year)
,			How How	vin	1)	206	24	1-110	100
	3		30. Name and address of person who completed cause of death (I	tem 23a) (Type,	Print)	1.6	H DOM	11000	00/22
			31. Date filed (Month, Day, Year) 32 Registrar's Si	diature diagram	1,1,017	VV	100019	INTO S	7000%
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Bruce Edward Diehl 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Sun If Under 24 Hrs. Hours Min. 42 Spready Oak Road Rising
Under 1 Year Cecil 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X**□M 2□F Director 217-30-2047 70 April 2,1935 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. Count 10d. Inside City Limits ral', or Itams 23e or 28e-f show Examiner , ust be notified at Director 1 ☐ Yes 2 No Cecil Risina Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42 Spready Oak Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 XNo Specify: Specity: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Edward Diehl Margaret Loretta Wellington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau Hazel Diehl/wife 42 Spready Oak Road, Rising Sun, MD 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Brookview Cemetery 4 □ Donation 5 □ Other (Specify) May 9, 2005 Rising Sun, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD uchand Point. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one course on each line. Immediate Cause (Final **Physician** Colon Cancy years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, flary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Oue to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of): as the burial-Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐ Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 KNo 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident investigation Funeral Director: stely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide McCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated 29b. Signature and title of certifier 23a) (Type, Print)

Northern Chesapedra Hospice, Elkton person who completed cause of death (Item 23a) (Type, Print) 5 31. Date filed (Month, Day, Year) State Registrar

			. 101	partment of Health and Mental Fertificate of Death	Reg. No.
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Death 3. Time of Death
	/Medic		ISABEL S. DAVIDOFF	MAY 1	, 2005 11:00 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Funeral		CASEY HOUSE  5. Social Security Number  6. Sex  7. Age (In yrs. last birthda)	ROCKVILLE   If Under 1 Year   If Under 24 Hrs.   8. Date of	MONTGOMERY  Birth 9. Birthplace (State or Foreign
	Funeral Director		026-22-3790 1□M 2X F 79 Yrs.	Months Days Hours Min. (Month, JULY	Dav. Year) Country)
	pu ,		Usual Residence of Decedent		
	aryla shov	<u>_</u>	10a. State 10b. County 10c. City, Town or l		10d. Inside City Limits 1 ☐ Yes 2 X No
	the M	Director	MARYLAND MONTGOMERY SILVER SE	RING 10f. Zip Code	10g. Citizen of What Country?
	with with	<u>ā</u>			
	Jeath In us	Funeral	3220 BIRCHTREE LANE  11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Specify Yes or	U.S.A. No- 14. Race - American Indian,
စ	or Itan	균	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show tha Madical Examinar must be mullikul at	d by	3 🖾 Widowed 4 □ Divorced If Yes, Give Year or Dates:	To tes 20 No Specify:	Specify: WHITE
2	"natu	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation be kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
12	within ane. than	m	Elementary/Secondary (0-12) College (1-4or 5+)		FEDERAL GOVERNMENT
	filed Hygid Sther	ပိ	17. Father's Name (First, Middle, Last)	OLOGIST  18. Mother's Name (First, Mid	
Maryland	should be nd Mental markad c	To Be	REUBEN SHARENSON	BESSIE	NEVELOFF
ary	should by selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of the selection of		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number or Rural Route Nu	
	and 2 Balth a n 27 ls			S. WINDSOR BLVD., LOS A	
ore	of He		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition	position (Name of Date ematory or other place)	20c. Location - City or Town, State
<u>Ē</u>	Pagas tment of tant: If it		`4 □Donation 5 □Other (Specify) MT. LEBAN		ADELPHI, MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		Sonold C. Stottlemuer	22. Name and Address of Facility ANZANSKY-GOLDBERG MEMOR 170 ROCKVILLE PIKE, ROCH	XVILLE, MD 20852
			23a. Part1. Enter the disease, or complications that caused the yeath. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respirator	ry arrest, Approximate Interval Between Onset and Death
	Physician	i i	Immediate Cause (Final disease or condition resulting in death)  a. ACUTE LEUKEMIA		0.130, 0.13 250.11
ŀ	/Medical Examiner		Due to (or as a consequence of):	La company of the second	
E		-e		OMA OF SPINE AND BRAIN	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
o,	an an rial-tr		resulting in death) Last Due to (or as a consequence of):		
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9	leath certifica attending ph d for usa as th	Med	IF FEMALE:		
Вох	ath cattend	lan/	23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery  Month Day Year
o	that the de ted by the a detached t	ysic	1 Yes 2 No 9 Unknown	- Other (specify)	
٣.	law requiras that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. C	Did tobacco use contribute to the cause of death?
rds,	quiras nn sign ufd be			1	☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown
Record	aw requir as been si 2 should	Completed			Vas an . 24b. Were autopsy findings available utopsy prior to completion of cause of
	9 4	mo;		p 1 □ Ye	erformed? death?
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check or	nly one)
of \	hys his	၉	1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	Residence 6 X Other (Specify) HOSPICE
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Division	Attending or death. actor: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		on (Street and Number or Rural Route Number,
<u>S</u>	al or A after I Dira d in b	erti	4 Homicide determined building, etc. (Specify)	City or	Town, State)
	To the Hospital or At within 24 hours after of To tha Funeral Dirac completely filled in by	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to investigation, in my opinion, death occurred at the tir	the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	10		I HAM IN	D35635	MAY 1, 2005
			30. Name and address of person completed cause of death (Item 23a) (Typ		
			JOSEPH KAPLAN, M.D., 6001 MUNCASTER 1  31. Date filed (Month, Day, Year)  22. Registrar's Signature	MILL ROAD, ROCKVILLE, MA	RYLAND 20855
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 0 5 2005  Registrar's Signature	uli	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 05 James Edward Fields Jr. 11:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13111 5th Street Prince George Bowie 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

No. 2 Yes Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 2/25/22 Birthplace (State or Foreign Country) **Funeral** 1**X**) M 2 □ F 83 Director 221-05-6297 Middletown, DE Usual Residence of Decedent 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic evant, the Madical Examination that ke modified at 10d. Inside City Limits 1X Yes 2 No Director MD Prince George Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13111 5th Street 20715 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XX Yes 2 □ No If Yes, Give Year or Dates: 1942 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. withIn 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Railroad Laborer 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be James Edward Fields, Sr. Annie (White) Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 & Department of Health ar Important: If itam 27 is any injury or other trau Helen J. Fields/ Wife 13111 5th Street, Bowie, MD 20715 e of Disposition (Name of Date 20c. Location · City or 20b. Place of Disposition (Name of cemetery, crematory or other place)
Delaware Veterans 05/13/200 5 Bear, Delaware 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation 21. Signature of unegal Service Licenses 22. Name and Address of Facility House of Wright Mortuary E. 35th Street, Wilm., DE 23a. Part1. Enter the disease or complications is a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 19802 Approximate
Interval Between
Onset and Death
months Immediate Cause (Final **Physician** disease or condition resulting in death) Prostate cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ hypertension, stroke 1 Yes 2 XNo 3 Probably 4 Unknown Completed anemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes X☐ No performed? 1 Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attanding Injury 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death, To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tom D28998 5-5-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel, MD Dr. Saini 9101 Cherrylane Ste-211 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY - 6 2005

hysicia /Medic		1. Decedent's Name (First, Middle, I	Last)				2.	Date of Death Month	n Day	Year	3. Time of Death
		Leroy F.	Fleming					May	10'	2005	12:11 A <sup>n</sup>
xamin	er	4a. Facility Name (If not institution, g			4b. City, Town,					unty of Death	
		3910 62nd Avenue		last hirthday)	Landov If Under 1 Year		LLS 24 Hrs. R	Date of Birth	Pri		eorge's
neral ector		577-52-7576	. Sex 7. Age (In yrs. 68		Months Days	Hours	Min.	Date of Birth (Month, Day, pr. 11	, 193	7 Wa	ish., DC
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any injury or other treumatic event, the Macical Exurtant rount be notified at once.	2	10a. State 10b. County		ty, Town or Lo		t- 77 - d	-1-4				Yes 2 N
	Director	Maryland Prince	George's		Fores	т неі	gnus	16	ng. Citizen	of What Cou	ntry?
		108 Talber	t Drive			207	45		Un	ited S	States
	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Or Dan, Mexicar	igin? (Specif	y Yes or No-		Race - Ameri Black, White.	
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	CO	12th 17. Father's Name (First, Middle, La	ist)		Sindery W		er's Name (i	First, Middle, N			:110
	To Be	John: Fle					Ro	salee	Ross		
	-	19a. Informant's Name/Relationship			ng Address (Stree						
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20.00		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	B □Removal from State	cemetery, cre	osition (Name of matory or other pla		Dat			on - City or T	
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once		21. Signature di Funeral Service Li	Stores	(()	4001 Be						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Francis Xavier Filardo May 2005 7:15 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis ElderCare Severna Park <u>Anne Arundel</u> 8. Date of Birth (Month, Day, Year) Oct. 22, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Funeral Months Days 1 XM 2 ☐ F Hours 45 Director 155-56-3227 1959 NJ Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show or other traumatic event, the Medical Exercities must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 382 North Drive 21146 USA "natural", or Itama 23a death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify ፩ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than any injury or other traumatic event, tre Me Elementary/Secondary (0-12) College (1-4or 5+) Northrop Gruman Electrical Engineer 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis A. Filardo Emilia Grace Cappiello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Filardo/Wife 382 North Drive, Severna Park, MD 20b. Place of Disposition (Name of cometery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ACremation 3 Removal from State 2005 Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park MD 21146 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) 050 PSI day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisaate or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physicien Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes a No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes investigation 2 Accident 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

Box 68760, P.0. Division of Vital Records, e Hospital or Attending PI 124 hours after death. e Funeral Director: After the letely filled in by the funera To the Hospital of within 24 hours all To the Funeral D

> 30, Name and address of person imp completed cause of death (Item 23a) (Type, Print) 86 LIECUX ennites 2/Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 3 2005 Registrar

Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 6, 2005 **Physician** Waverly Lawrence Griffin 2:15 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6232 Albritton Lane Salisbury Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Days 225-56-1975 Director 61 6/11/1943 <u>Virginia</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 show any idury or other traumatic svent, the Medical Examinant matter by indillad at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director Maryland Wicomico 1 ☐ Yes 2 ▼No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6232 Albritton Lane 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Tri-State Beverage Elementary/Secondary (0-12) College (1-4or 5+) Owner Service, Inc. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Dennis Griffin Virgie Realand McNanara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Ann Davidson Griffin/wife 6232 Albritton Lane, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Woodlawn Memorial 5/9/05 Norfolk, VA 4 □ Donation 5 □ Other (Specify) Gardens 22. Name and Address of Facility
Holloway Funeral Home Professional Association
Holloway Funeral Home Professional Association
Salisbury, MD 21804 Signature of Funeral Service Licensee Crocomod CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ZYN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physiclan: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physiclan Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes completely filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and the of cert 29d. Date signed (Month, Day, Year) HU056197 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 218 NOWAN ST SAILLY ND 31. Date filed (Month State 6 2005

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician MAY 07. 2005 6:26A GERTRUDE EMMALINE GORMAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner 4265 MOCKINGBIRD CIRCLE WALDORF CHARLES If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 3 TY 87 Director 24, 1917 NEW JERSEY 577-30-0423 MAY Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show 1 Yes 2 No Director MARYLAND CHARLES WALDORF 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number CIRCLE 20603 4265 MOCKINGBIRD U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status iled within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married the Medical Examin ō Maryland 21215-0036 1 ☐ Yes 2√∑XVo Specify: þ 3 ₩ Widowed 4 Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT OWN SELF other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be for and Mental F THOMAS CLEVELAND ADELINE MOLT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GRANDpermit. Pages 1 and 2 Department of Health a Important: If item 27 Is item 27 ESTEVEZ-DAUGHTER MARY E. 20b. Place of Disposition (Name of cemetery, crematory or other place)

20b. Place of Disposition (Name of cemetery, crematory or other place) MD 20603 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition Murial 2 Cremation 3 Removal from State = 5 4 □ Donation 5 □ Other (Specify) TRINITY MEM. GDNS. 5-11-05 WALDORF, MARYLAND injury M00479 22. Name and Address of Facility 21. Signature of Funeral Service Licensee any ir RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND uch as cardiac or resp Approximate Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or a consequence of): /Medical **Examiner** Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No for 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2E No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred funeral 27. Manner of Death 28b. Time of Injury at Work? After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours at To the Funeral Completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ath 05 D-52289 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NALIN MATHUR, MD 31. Date filed (Month, Day, Year) 10 ST.PATRICKS DR. SUITE404 WALDORF, MD. 20603 State MAY 1 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Edward HAW-Kins Baltimore, Maryland 21215-0036

			ype or Print in B				-		•	
		1 - For State Registrar AMEND ITEM #26	State of Maryland CCHD DB PER PHYS. 5/6/05		irtment of F tificate of			giene Rog. No.	005	16954
Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of De.	ath Day	Year	3. Time of Death
Physicia /Medic		Edward William	Hawkins				MAY	4	2005	8:57 PM
Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of Dea	th	4c.	County of Death	
		CIVISTA MEDICAI				PLATA			CHARL	
Funeral Director		5. Social Security Number 6. Sex 128-16-2535 Usual Residence of Decedent	7. Age (in yrs. i	31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	Coun	lace (State or Foreign http) / land
land ow		10a. State 10b, County	10c. City	y, Town or Loc	ation				1	0d. Inside City Limits
the Maryland r 28e-f ehow notified at	tor	Maryland Charles	W	laldorf						1 ☐ Yes 2X☐ No
death with the ims 23a or 28e r must be noti	Directo	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Coun	itry?
23a c	a D	11862 Oak Manor Dr	ive			20601			USA	
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	d by	3 X Widowed 4 □ Divorced	Year or Dates: WWII			Specify.			Specify: D1	ack
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e filed within 72 hours Il Hygiene. other than "natural", /ent. The Madical Ex-	ပိ	17. Father's Name (First, Middle, Last)			tock Cle		ame (First, Middle,	Maiden	US Gove	ernment
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2 should be and Mental vis markad or raumatic ev	T <sub>0</sub>	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing	a Address (Street		J. Thoma	_	r Town, State, Zio	Code)
0 = 1		Richard D. Hawkins	- Son	F			laldorf,		100	,
f Health Itam 27 other tr		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of patory or other place		Date		cation - City or To	wn, State
Pages nent of ont: If it		1 Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)			' Cemete		-05	Brva	ntown, M	larvland
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DHMH 17 Rev 1/2001

State Registrar

Division of Vital Records, P.O. Box 68760,

CENTER STE, 202&210 WALDORF, MD 20602

ROBERT T. PACE MD 12070 OLD LINE

31. Date filed (Month, Day, Year)

MAY 0 6 2005

32. Refistrar's Signature

			For State Registrar	State of M	Marylan		rtment of I tificate of		Mental Hy	giene Reg. No.	005	16955
	Physici		1. Decedent's Name (First, Middle, Las Ernest Haine:	•				-	2. Date of De Month April	Day	2005	3. Time of Death 12:05 A M
	/Medic Examin		4a. Fecility Name (If not institution, give				,	or Location of Dea	ath	4c. C	County of Death	J
	Funeral Director		3,0 == 3,3= 1,		Age (In yrs.	last birthday) 5 Yrs.	If Under 1 Year Months Days			th Year)	Howard 9. Birthp Cour Sout	lace (State or Foreign http://
	ryland how		Usual Residence of Decedent  10a. State  10b. County		10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
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	ath with		6217 Slend					21044			Jnited S	
036	ours after de ai', or iteme Examiner m	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🌠 Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 □Xes 2{ If Yes, Give Year or Date	s? ⊒No	i	Was Decedent of life Yes, specify Cub		(Specify Yes or No arto Rican, etc.)	1	4. Race - Americ Black, White, Specify:	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Iteme 23a or 28a-f ehow event, I're Medical Exartifizer must be nutilised at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 7 th	ucation de completed) College (1-4d	or 5+)	(Give life. l	dent's Usual Occu kind of work done DO NOT use retire Maintena	during most of ward)		16b. Kind	d of Business/Ind	
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Maryland	and Mental is marked o eumatic eve	2	W1111 19a. Informant's Name/Relationship (7	e Haines iype, Print)	worth	19b. Mailir	ig Address (Stree	t and Number or I	Paul 		Charles Town, State, Zip	Code)
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Ba	perm Depa impo any i		I om T.	Stewa	TI		4001 Ber	nning Rd	Stewart I	Wash.		)19
	Physician /Medical		23a. Part1. Enter the disease, or come shock or heart failure. List only of Immediate Sause (Final disease or condition resulting in death)	aUros	epis		er the mode of dy	ing, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death 9 Days
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Division of Vital Records,		Completed		, , , , , , , , , , , , , , , , , , , ,					24a. Was auto perfo 1 U Yes	DSV	24b. Were auto prior to co death? 1 \( \subseteq Yes	psy findings available mpletion of cause of 2 \( \square\) No
Vita	sicien: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2X No	Hospital: 1 □ Inc	atient 2 🗆	ER/Outpatier	at 3 DOA	th a m	eath (Check only) Home 5 Res		□Other (Specif	iv)
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	To the Hospitel within 24 hours of To the Funerel I completely filled	edicai	29a. Certifier 1 Check only 2 Medical Examone)	ysician: To the be niner: On the basi and manner	s of examina	owledge, deatl ation and/or in	n occurred at the t vestigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time,	date and p	and manner as s place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0-60	1.0	AA T		ise number			signed (Month,	
Q	0-1		30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type.		)43323		<i>P</i>	April 26	, 2005
	r 6		Abeda Ali Kh	an 1082	0 Hick	cory Ri	dge Road	l, Columb	oia, MD	21044	+	
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 9 6 2005	Dady	istrar's Signa	ho	E.					

State of Maryland / Department of Health and Mental Hygiene 16956 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 2005 Elizabeth April 29, May Hammond 11:00 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery

9. Birthplace (State or Foreign Country) (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 24 1913 Maryland **Funeral** Days 1 □ M 2 F Months Min. Hours 216 03 4591 91 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location Hygene Hygene other hen "natural", or Items 23a or 28a-f snow vent, tre Mydical Examination ast be nutified at 10d, Inside City Limits 1 ☐ Yes 2 No Maryland | Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1208 Schindler Drive 20903 Funera USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 至 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Importent: If item 27 Is marked other then "natural", or Iten any injury or other treumatic event, the Musical Exertin at Once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes XXNo Specify: þ Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be 2 Charles Enos Hipkins Susan Rebecca Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 Schindler Drive Silver Spring, Maryland 20903 Susan Hammond / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 5/5/2005 Baltimore, Maryland ` 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Livense 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, MD20904 Elus art1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or hear failure. List only one cause on each line. Interval Between Onset and Death Imme state Cause Final disease or Condition **Physician** Respiratory Failure 2 Days /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Chronic Obstructive Pulmonary Disease Years Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Congestive Heart Failure Years resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical Hypertension Years. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ĺ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ filled in by the funeral director, page 2 should be Be Completed 1 ☐ Yes 2 ☐ No 3XX Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 1

Inpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the the 29b. Signature and title of certifie 0 29c. License number 29d. Date signed (Month, Day, Year) D19294 April 30, 2005 ddress of person who completed cause of death (Ite ype, Print) John R. Melrich, M.D. 911 Russell Avenue Gaithersburg, Maryland 20879 31. Date filed (Month, Day, Year) . Registrar's Signature State 05 Registrar

			1 - ForAmend Item 12&1	State of Maryla Oa per info	and / Depa rmant 68	rtment of H 43 5–24–0 fificate of L	ealth and M 5 tas Death	lental Hygi Re	ene UUT	16957
			1. Decedent's Name (First, Middle, Last)		1-			2. Date of Death Month		3. Time of Death
	Physici /Medic		GRRFIELD KO	OSEVELT	404			Month.	29-200	5 7=38PM
	Examin		4a. Facility Name (If not institution, give s	treet and number)			Location of Death		4c. County of Dea	4
				rial Hospit		FREDE			FREDER	
	Funeral Director		5. Social Security Number 6. Sex 15-114-1667	M 2□F 7. Age (In)	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, JAN-31,	1923 9. Bi	rthplece (State or Foreign ountry) M.C.
	p .		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Loc	eation				10d. Inside City Limits
	shov	'n	and F			1				1 MYes 2 □ No
	28e-f	ecto		rick	rea	10f. Zip Code		10	g. Citizen of What C	ounto/?
	with sa or	Funeral Director	177 What 145	South St.	Street	21	701		115	
	ms 23	era	11. Marital Status	2. Was Decedent Ever is	n U.S. 13. W	as Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any figury or other traumatic event, I're Medical Exactinar must be notified at an once.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No 11 Yes, Give Year or Dates:		Yes, specify Cubar  ☐ Yes 2☐ No	n, Mexican, Puerto Specify:	Hican, etc.)	Specify: /2	lack
215-0036	P hou	ed	15. Decedent's Educ	eation		ent's Usual Occupa		1	6b. Kind of Busines:	
715	nin 72 In "na Media	piel	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give F	and of work done d O NOT use retired,	uring most of work )		AlimiNi	m PLANT
2	od with	Completed	8 714		P	OT LINE				7 2/1/01
Maryland	d be filed antal Hygid and other c event, I	Be	17. Father's Name (First, Middle, Last)  6ARFIELD R. HOY	SR				e (First, Middle, M FOSSETT	aiden Sumame)	
7	should be and Mental s marked o umatic eve	1º	19a. Informant's Name/Relationship Type	pe, Print)	19b. Mailin	g Address (Street a			City or Town, State,	Zip Code)
	and 2 sealth are 1 27 is		KIMBERLEY John	ISON (DAU)	1900 V	NARRIOR	BROOK D.	V. Germa	intoun N	1d. 20874
re,	s 1 a of Hea item othe		20a. Method of Disposition		b. Place of Dispos	sition (Name of atory or other place		Date 2	Oc. Location - City o	Town, State
Ē	Pages nent of ant: If its		1 MBurial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	ESTHAYE	No Brento	3-15	-05 /	-RED. MC	<i>l</i> ,
Baltimore,	Departic Departic Importe any inju		21. Signatur of Funeral Service Lives		22.	Name and Addres	s of Facility	Ry L. RC	LLINS F	21701
			23a. Part1. Enter the disease, or complic	cations that caused the c						Approximate
	<b>8</b>		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a con		Cardio	VKSCULC	av Des	case	Yeurs
6	Examiner									6
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con-	sequence of):					
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			·			···	
50,	oe exectan a	EX	resulting in death) cast	Due to (or as a con	sequence of):					
8760,	icate be executed physician and s the burial-transit	dical	d d	ř						
9 X	attending for use as		IF FEMALE:	3c. If yes, outcome of pre	egnancy				23d. Date of de	alivery
Вох	atter d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
o.	t the c by the achec	hysi	9 Unknown	9□ Unknown						
S, D	The law requires that the death certifities that been signed by the attending tage 2 should be detached for use a	by P	Part II. Other significant conditions con	Inbuting to death but not	resulting in the un	derlying cause give	n in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ğ	w require been sig should b		Bladde	er ca	ucer			1 Tes	2 □ No 3 □ F	robably 4 Unknown
Record	law re as be 2 sh	Completed	for yper	tension	7			24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
_		Con						perform 1 Yes 2	ed2 death? No 1 ☐ Ye	<b>-</b>
Vital	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					h (Check only one	)	
of	Physic this c	5	1 XYes 2 No No 27. Manner of Death	ospital: 1 ☐ Inpatient 2 28a. Date of Injury	2 ER/Outpatient 28b. Time of		4   Nursing Ho		ice 6 Other (Spi	ecify)
uc	ding Phy h. After thi funeral d	tion	1 Natural 5 Pending	(Month, Day Year		28c. Injury Work M 1 □ \	es 2 □ No	28d. Describe how	v injury occurred	
Division	Attend death ctor: /	fica	3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, stre			28f. Location (Stre	eet and Number or F	lural Route Number,
ó	s after il Dire	Certification:	4 Homicide	building, etc. (Sp	ecity)			City or Town,	State)	
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certificy completely filled in by the funeral director.	edical (	(Check only 2 Medical Exemin	ician: To the best of my er: On the basis of exam	knowledge, death nination and/or inv	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the car red at the time, da	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	ithin 2 o the	Med	29b. Signature and title of certifier	and manner stated.		29c. License			d. Date signed (Mon	
)	2 7 8 7		10,	VIJA AS	MIT	) 7.	3710	7	5-5	-2005
	•		30. Name and address of person who con	mpleted cause of death	Item 23a) (Type I	Print)	-616		0 0	acco
	り		Alan Hohr	er MD	/ /	est 7th	-Street	Frede	rick M	D21701
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature	South			Y	

			1 - For State Registrar	State of Ma	ryland		rtment o				giene Reg. No.	05	169	58
	o Physic	an	1. Decedent's Name (First, Middle, Las. William Les	;) :lie			Hawhan	o.h		2. Date of De Month	ath Day	Year	3. Time of	
	/Medi Examir		4a. Facility Name (If not institution, give 13908 Weaver Ave.				Harbau  4b. City, Tow  Maugan	m, or Loc	ation of Death	May	4c. Cou	2005 nty of Death		Р м
	Funeral Director		5. Social Security Number 6. Se 217-12-2398	x 7. Age ▼M 2□F 8		ast birthday) Yrs.	If Under 1 Y	ear If	Under 24 Hrs. ours Min.	8. Date of Bin (Month, Da April 2	th y, Year)	9. Birth	place (State on ntry) yland	r Foreign
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ire Madical Exemple at Livet Last be multipled at 2006.	Director	10a. State         10b. County           MD         Washing           10e. Street and Number	ton		, Town or Lo		de			10g. Citizen		10d. Inside Cit	•
	ter death witi Itams 23a o it er t. wat be	Funeral D	13908 Weaver Ave	12. Was Decedent E Armed Forces?				1767 of Hispar Cuban, M	nic Origin? (S lexican, Puert	pecify Yes or No o Rican, etc.)	U.	S.A. Race - Ameri Black, White,	can Indian,	
15-0036	72 hours af "natural", or colical Exem	by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Edi (Specify only highest grace)		° 194	45 16a. Deced	ent's Usual Ockind of work do	cupation	g most of wor	king		city: Whi		
Maryland 21215-0036	be filed within tal Hygiene. d other then event, it e Meren	Be Completed	Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	College (1-4or 5+	+)		ic Fabi	ricat		ne (First, Middle,			nufact	uring
	nd 2 should lith and Men 27 is marka r traumatic	To	Howard Clinton Hai 19a. Informant's Name/Relationship (7) DebrahSiarkowski/I	rpe, Print)				eet and I	Number or Ru	uldwell in all Annual Route Numbers	er, City or Tov	vn, State, Ziji 21742		
Baltimore,	Pages 1 a tment of Heatant: If item jury or other		20a. Method of Disposition  1 M Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,		1	ace of Dispos metery, crem t Have	sition (Name o natory or other n Cemet	f place) tery	5/16	Date	20c. Locatio	n - City or T	own, State	
Bai	permit Depar Impor any in		21. Signature of Funeral Service Licens  Surell Surell  23a. Part1. Enter the disease, or comb	V	the death	16	Name and Ad	nsyl	vania	st Haver Ave., Ha	gersto	al Ch	ape1 D 2174 Approximate	
8760, <	Physician and /Medical Examiner and the bruial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	conseque	ence of):	cer						Interval Betwonset and D	eath
.O. Box 6	that the death certificate led by the attending phys detached for use as the	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal	death 3 🗌	Ectopic pregna Other (specify					Date of delive	*	ear
s, D	w requires that the sbeen signed by the should be detache		Part II. Other significant conditions co	ntributing to death but	not result	ting in the un	derlying cause	given in	Part I.				ne cause of de	
al Reco	The law ate has b page 2 sl	e Completed	25. Was case referred to medical							24a. Was a autop perfor	med? 2 No	prior to co	psy findings a mpletion of car 2 No	vailable use of
Division of Vital Record	this al dir	To B	examiner?	1 Inpatient 1 Inpatient 28a. Date of Injury (Month, Day	2	R/Outpatient 28b. Time of Injury	28c. I		☐ Nursing H	th Check on or or or or or or or or or or or or or	ence 6 🗆 C		y)	
Divis	or A offer offer or by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur- building, etc.	(Specify)					28f. Location (S City or Town	n, State)			91,
	tha Hospital in 24 hours a the Funaral I pletely filled	edical	29a. Certifier 1 ✓ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of e and manner state	axamınatıc	ledge, death on and/or inv	occurred at the estigation, in m	e time, da iy opinior	ate and place, n, death occur	and due to the c red at the time, d	ause(s) and r	manner as st e, and due to	ated. the cause(s)	
)	To the within 2 To the complet	M	29b. Signature and title of certifier  Muchsel 9.	Melann	cL	mo.	29c. Lic	ense nun	1667	2	29d. Date sign	/ 2	Day, Year)	
	H		30. Name and address of person who complete the complete that the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	ompleted cause of dea	ath (Item 2	23a) (Type, F	Print) Nedle	cl	Cany	ics b	Eger11	Lun	MO	
)(C	Sta Registr		MAY 1 8 20	05 Hague	a dignatu	do	well !							

			1 - For State Registrar  1. Decedent's Name (First, Midd		of Maryla		artmeni rtificate			ind M	lental Hy	Reg. No.	05	169	-
	Physici /Medio Examir	cal	Virginia  4a. Fecility Name (If not institution  Memorial Hospi	Lee on, give street and nu		lipsley	4b. City,		Location of	f Death	May 10	, 2005 4c. Co	Year ounty of Deat gany	3. Time of 1535	
	Funeral Director		5. Social Security Number 219-14-6308 Usuel Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yr:	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt Oct 23,		9. Birt	hplace (State o	or Foreign
	e Maryland la-f show	ctor	10a. State 10b. County	gany	10c. C	City, Town or Lo	perland	t						10d. Inside Ci	
	th with the 23a or 28	Funeral Director	10e. Street and Number 512 Winifred Re	oad			10f. Zip		1502				of What Co	untry?	
JU36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Its Mudical Examinant must be neitlisd at ODGE.	by	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorce	nied Armed Fo	ve X No	ł	Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto I	ecify Yes or No- Rican, etc.)		Race - Ame Black, White Pecify: Whi	etc.	10
יכוצן.	within 72 h ene. than "natu	Completed		nt's Education est grade completed) College (	1-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us maker	l Occupa k done d e retired	ition Juring most )	of workii		16b. Kind	of Business/I	Industry	
Maryland 21215-0036	uld be filed Mental Hygid Irkad othar Itic evant, II	To Be Co	17. Father's Name (First, Middle, James Willian			TIOTHE	Hanci				(First, Middle, Trapp B	Maiden Su			
, mar,	alth and I		19a. Informant's Name/Relations Stephanie Ring		ughter	19b. Mailir 10 B	ng Address lackis	(Street a	nd Number Avenu	r or Rura I <b>C</b>	Route Numbe	r, City or To erland	own, State, Z	D 21502	2
Baltimore,	Pages 1 ament of He ment: If item ant: If item ury or othe		20a. Method of Disposition  1 🗷 Burial 2 Cremation  4 Donation 5 Other (S		Chain	Place of Dispo cemetery, crer Mary's C	matory or oti	her place	9)		5/13/2005		ion - City or 1 berland		D
ם ב	permit. Departr Importa		21. Signature of Funeral Service	Licensee	ans	1/1- 22					me, PA Cumberl	and. M	D 21502	2	
8/60,	/Medical by American and // // // // // // // // // // // // //	ical Examiner	23a. Part1. Inter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to instruction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aBILA		PNEUMON requence of):		of dying	, such as c	eardiac o	r respiratory an	rest,		Approximate Interval Betwo Onset and D	veen Death
r.O. BOX 00	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown		oirth 2 ☐ Fet nant at time of	tal death 3	Ectopic pre					23d.	Date of delive		'ear
	quires that n signed to lid be det	by	Part II. Dther significant conditi DIABETES ME		eath but not re	sulting in the ur	nderlyi <b>n</b> g ca	use give	n in Part I.			bacco use o		the cause of de	
משבו ופי	tictan: The law requir certificate has been si rector, page 2 should	e Completed	CHRONIC OBS		ULMONA	RY DISE	ASE					med? 2 No	4b. Were aut prior to co death? 1 ☐ Yes	opsy findings a ompletion of ca	ivailable tuse of
DIVISION OF VITAL RECORDS,	ttending Phys death. :tor: After this :the funeral di	Certification; To Be	examiner?  1 Yes No  27. Manner of Death  1 Natural 5 Pendir  21 Accident investi  3 Suicide 6 Could	Hospital: 152 28a. Date (Monggation not be not be printed 28e. Place	of Injury th, Day Year) of Injury - At I	ER/Outpatien 28b. Time of Injury	28 M	c. Injury Work 1  Y	r. 4 🗆 Nurs	sing Hom 2	Check on or one 5 Reside 8d. Describe he	ence 6   ow injury oc	curred		90 <i>r</i> ,
2	spital or nours aftr neral Dir / filled in		29a. Certifier 1 Certifying	ng Physician: To the	ng, etc. (Spec	owledge, death	occurred a	t the time	e, date and	place, a	City or Town	ause(s) and	I manner as	stated.	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifie	and man	esis of examination of stated.	ation and/or inv	29c.	License	number	occurre	at the time, d	ate and pla	gned (Month)	Day, Year)	
	Sta Registr		30. Name and address of person Habib Chotar 31. Date filed (Month, Day, Year)	ni, M.D. l	30 Peni	nsylvan eature	ia Av	enue	; Cum	ber1	and, MI	2150	2		

MOCKMAC, RODER

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - For Stata Registrar	State of Ma	arytaria /		tificate of		wichtarry	Reg. No		1696
		Decedent's Name (First, Middle, L.	ast)					2. Date of De	ath		3. Time of Dea
ıysici. Medic		Robert Cla	re Koerme	er				May 9,	, 20		12:25
kamin	ner	4a. Facility Name (If not institution, gi Greater Baltimo:	· ·	Center			or Location of Dea WSON	th	40	Baltim	
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State Registrar 31. Date filed (Mont) 18 2005

Jose Abrejo 05-3065 AKG

306.	0	-	FOI	artment of Health and Me ertificate of Death		ene 2. No.	16961
5	r A		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Jose Oscar Abrego Lopez			2005	11:40 A M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deatl	
			University Hospital	Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) Co.	nplace (State or Foreign untry)
	Director	-	213-63-1243		07-10-19	78 E1	Salvador
	and *	-	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits
	Maryl.	5	Maryland P.G. Suitlan	nd			1 ☐ Yes 2 No
	r 28e-f show	Directo	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	untry?
	3e or	<u> </u>	3500 Pearl Drive #3	20746		El Salv	ador
	death ms 2	-		Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Ame	
ယ	or iter	Ē	1X Never Married 2 Married 1 ☐ Yes 2X No	1 XYes 2 No Specify: Salv		Black, White Specify: Whi	
03	10	å p	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	TEATES ZEINO OPECHY. DZIIV			
5-0	72 hours "natural",	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	10	6b. Kind of Business/	-
21	Aithin ne.	ld I	Elementary/Secondary (0-12) College (1-4or 5+)		J	J.E. Wood	a sons. Inc.
121	filed within Hygiene. Ither than and, if a My	ပိ	11th ROO:	18. Mother's Name	(First Middle Ma	aiden Sumame)	Inc.
Maryland 21215-0036	0 = 0 \$	Be			pez	alddir damame,	
Z Z	d Mer d Mer nark	2	Jose Antonio Abrego  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	ing Address (Street and Number or Rural		City or Town State 2	Tin Code)
Ma	d 2 s th an 7 is r treur		48'	29 Homer Avenue itland, Maryland, 2		,,,	,
e,	1 an Heal Heal ern 2		20a Method of Disposition 20b, Place of Disp	osition (Name of D		Oc. Location - City or	Town, State
о́Г	or of		1 Burial 2 Cremation 3 Removal from State	ematory or other place) Semetery 05-13	3-05 E	1 Salvador	
Baltimore,	artme artme orten injury		4 Donation 3 Other (Specify)	22. Name and Address of Facility W. H.	Bacon F	uneral Ho	me, Inc.
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked any injury or other treumatic e once.			447 14th Street, N.			
			23a. Part I. Enter the disease, or complications that caused the death. Do not en	nter the mode of dying, such as cardiac or	respiratory arres	st,	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	e minies	, )		Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	2 / Julia			
	Examiner		V				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	cuted	Examiner	that initiated events C.				
ó	be executed sicien and burial-transit	m X	resulting in death) Last Due to (or as a consequence of):				
3760,	et % et	lcal	d				
9	ertifica ling pt e as t	Med	IF FEMALE:				
Вох	ath certif attending for use a	lan/		□Ectopic pregnancy		23d. Date of deli Month	very Day Year
P.O. I	t the de by the a tached f	Physiclan/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			
	that the sed by detac	h h	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Division of Vital Records,	w requires that been signed by should be det	d by			1 ☐ Yes	2 00 3 □ Pr	obably 4 Unknown
202	w requestrated	Completed			24a. Was an	24b. Were au	topsy findings available
Re	he lav e has ge 2	дша			autopsy	ed? death?	topsy findings available completion of cause of
a	iclen: Th certificate rector, pag	င်	25. Was case referred to medical	26. Place of Death			2 No
Ž	ysiclen: The is certificate his director, page	00	examiner?  1 X Yes 2 No  Hospital: 1 X Inpatient 2 ER/Outpatient	Other		ce 6 ☐ Other (Spe	cufy)
of	g Phys ter this neral di	To To	27. Manner of Death 28a. Date of Injury 28b. Time		8d. Describe how		-
lo	nding Ph ith. : After th e funeral	atlo	1 □ Natural 5 □ Pending (Month, Day Year) Injury 2 Accident investigation 5-3-05 8:12		Decease	d tell	
Visi	Attender deatlector:	ifle	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, so building, etc. (Specify)		28f. Location (Stre	set and Number or Ru	iral Route Number, 08 Indiana St
Ö	s afte	Certification;	Constructi	on site 1		Airforce B	ase MD.
	To the Hospitel or Attenwihin 24 hours after deatl To the Funeral Director:	cal (	29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch	ith occurred at the time, date and place, a	and due to the cau	use(s) and manner as	stated.
	he H in 24 he Fi plete	edical	one) and manner stated.				
	To To To To	Σ	29b. Signature and title offcendier	29c. License number  OCME		d. Date signed (Monti ay 4, 2005	
	2 7		X W X VV	OGNE		-, , 400	
6	124		30. Name and address of person who completed sadse of death (Item 23a) (Type 5 10 10 00 AV	111 Penn Street	Baltim	ore. Marvl	and 21201
	St	ate	31. Date filed (Month, Day, Year) 2. Registrar's Signature			,, 1	
	Regist		MAY 0 6 2005 Keen & Special	We .			

		•	State of Maryland / D		rtment tificate			ind M		giene Reg. No. (	005	159	162
			Decedent's Name (First, Middle, Last)						2. Date of De	ath Day	Year	3. Time of	
	Physicia /Medic		Doris Melicita Layne						May		2005	8:20	a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, T	own, or	Location o	f Death		4c. Co	unty of Death		
			10526 Westlake Drive #101			thes		74 Hen			ontgome		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt. 1 ☐ M 2 ☒ F 99	thday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da	n y, Year) 1006		place (State o	ir Foreign
	Director		Usual Residence of Decedent						02-04-	1906	Irii	nidad	
	land ow		10a. State 10b. County 10c. City, Town	or Lo	cation							10d. Inside Ci	
	Mary -f sh lied	tor	Maryland Montgomery Betheso	da								1 🗆 Yes	2 <b>X</b> No
	r 28e	irec	10e. Street and Number		10f. Zip (	Code				10g. Citizen	of What Cou	ntry?	
	th wit	alD	10526 Westlake Drive #101		20	854				U	J.S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show any Injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1X Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes, Sive 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces Forces Forces Forces Forces Forces Forces Forces Forces Forces Forces Fo		Vas Decede f Yes, specif I □ Yes 2			gin? (Spe , Puerto	cify Yes or No Rican, etc.)		Race - Ameri Black, White, ecity: B1a	etc.	
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ַק	e filed Il Hygie other vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle,	Maiden Sui	mame)		
Maryland	uld be Aental rked o	To E	Joshua Layne						Lums				
ary	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (Type, Print)	Mailin 14	39th	Street a	nd Numbe e.t	r or Rura	l Route Numbe	er, City or To	own, State, Zij	Code)	
	1 and 2 Health tem 27		Vida Thompson/Daughter Bre	ent	wood,	Mar	yland	1, 20	722				
ore	of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	y, cren	sition (Nami natory or oth	e of ner place	)	L	ate	20c. Locati	ion - City or T	own, State	
Ĕ	Pages ment of tent: If its		`4 □Donation 5 □Other (Specify) Ft. L:	inc	oln Ce	emet	ery	05-0	07 <del>-</del> 05 Bacon	Brent	wood,	Maryla	ınd
Baltimore,	permit. Departr Importe any Inji		21. Signature of Funeral Service Licensee  Wanda C, Bacon, CC361  23a. Part1. Enter the disease, or complications that caused the death. Do n	3	447 14	th	St.,	N.W.	Wash.	, D.C.			
8760,	Cheath certificate be executed was as the burial-transit of for use as the burial-transit	Ilcal Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of	of): Of): of):	De		la	ret	to	uðle	rut	Interval Bat Onset and I	Death
.O. Box 6	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pre Other (spe					23d	. Date of deliv Month		Year
Δ.	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in	the ur	nderlying ca	use give	n in Part I.		23e. Did to	V	contribute to t	he cause of d bably 4 🗀	
Records,	The law require	Completed							24a. Was autop perfo 1 Yes	an 2 psy rmed? 2 2 No	4b. Were auto prior to co death? 1 \(\sum \text{Yes}\)		available ause of
Vital		Bec	25. Was case referred to medical examiner?				26. Place	of Death	(Check only o	-			
<u>&gt;</u>	Physician: r this certific ral director,	70	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatien			4 🗆 140		me 5 🏋 Resid			fy)	
ion of	Attending PI r death. ector: After the		1 XNatural 5 Pending (Month, Day Year) II 2 Accident investigation	Time of njury	M 28	lc. Injury Work	at ? ′es 2 □ l		28d. Describe I	now injury o	ccurred		
Division	Hospitel or Attence 24 hours after death Funerel Director: stelly filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, str	eet, factory,	office			28f. Location (S City or Tov		umber or Run	al Route Num	ber,
	To the Hospitel or Attending Ph within 24 hours after death.  To the Funerel Director: After the completely filled in by the funeral	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examinar: On the basis of examination and and manner stated.	d/or in	occurred a vestigation,	it the tim in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and date and pla	d manner as s ace, and due t	stated. the cause(s	;)
	To the within 2 To the complet	ž	29b. Signature and title of certifier		29c.	License	number			29d. Date si	igned (Month,	Day, Year)	
	(		Lin elsalles	di	1	1/2	12	5/7	0	May	5, 200	5	
٦,	2119		30. Name and ediress of person who completed cause of death (Item 23a) (	Туре,			_		n Road				
$\leq$			Gita Bakshi, MD			the	sda,	Mary	1and, 2	0814			
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 0 6 2005	dos	de								

			1 - For State Registrar	State of Maryland / [	Departmen <i>Certificate</i>	t of Health e <i>of Death</i>	and Mental H	ygiene)	005	16963
	n		1. Decedent's Name (First, Middle, Last,				2. Date of [		V	3. Time of Death
	Physici /Medi		DANIEL J.	LEONARD			Month May	Day	Year 2005	8:25 p <sup>M</sup>
1	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City,	Town, or Location	of Death	4c. Co	ounty of Death	
			Manor Care		Ве	thesda		Mo	ntgomer	У
	Funeral		Social Security Number     6. Security Number		Monthe	1 Year If Under Days Hours	Min. 8. Date of E	Birth	9. Birthpla	ace (State or Foreign
100	Director			M 2□F 90	Yrs.	Days Hours		3, 1915		
	D .		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow						
	eho eho	-	Maryland Montgome		thesda				10	d. Inside City Limits
	h the Maryland rr 28a-f ehow	ectc	•	11. BC						1 X Yes 2 No
	with the Maryland to or 28a-f ehow	듬	10e. Street and Number		10f. Zip			10g. Citizer	of What Count	ry?
	a 23g	Funeral Director	11001 Arroyo Driv			852			S. A.	
	er de Item	une	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Deced	ent of Hispanic O ify Cuban, Mexica	rigin? (Specify Yes or Nan, Puerto Rican, etc.)	10-	Race - America Black, White, e	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes ŽŽ No If Yes, Give Year or Dates:	1 Yes 2	No Specify	r:	Sp	ecity: Wh	ite
21215-0036	hou	edt	15. Decedent's Edu		Decedent's Usua	LOccupation		10h Kind		
15	in 72 n" r	Completed	(Specify only highest grade	completed)	(Give kind of wor	k done durina mo	st of working	100. Kinu	of Business/Indi	ustry
12	with than	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Chemi			II C	0	
D	Hyg othe	BeC	17. Father's Name (First, Middle, Last)		OHEMIL		ner's Name (First, Middle		. Gover	nment
Maryland	id be ental kad	To B	Sam Levinsky			.Te	ennie (Unas	certai	nahla)	
ary	shou nd M mer	-	19a. Informant's Name/Relationship (Ty	pe, Print) 19b	. Mailing Address		per or Rural Route Num			Code)
M	nd 2 lith a 27 is r trau		Harris K. Leonard				e, N. Bethe			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mantal Hygiens. Important: If item 27 is marked other than "natural; or liems 23a or any injury or other traumatic event. If a Madical Examinational page.		20a. Method of Disposition	20b. Place of	Disposition (Nam	e of	Date		ion · City or Tow	
OLL	Single Single		1 ☑ Burial 2 ☐ Cremation 3 ☑ R  1 ☑ Donation 5 ☐ Other (Specify)	emoval from State	ry, crematory or of		- 5/5/2005	77 11	<i>C</i> 1 1	
=	artme ortan injur	- 0	21. Signature of Funeral Service License			d Address of Facil	n 5/5/2005	Falls	Church	, Virginia
Ba	Deparent Deparent Important any ir		Donald C X	Jan ser es	Danzan	sky-Gold	berg Memori	lal Cha	pels, I	nc.
			23a, Part1. Enter the disease, or compli	cations that caused the death. Do n	1170 R	rckville.	Pike Kock	Offix	Mary 1a	nd 20852 Approximate
		8 1	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	•		, o. e,g, o.co., a.	ourando or respiraçory	urrost,		nterval Between Onset and Death
A	Physician /Medical		disease or condition resulting in death)	Pneumonia					1	Hours
10	Examiner			Due to (or as a consequence of	of):					
1.0		-a	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):					
	nsit	딭	if any, leading to immediate cause. Enter Underlying Cause (Disease or njury that initiated events		,-					
,	al-tra	Examiner	resulting in death) Last	Due to (or as a consequence of	of):					
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dlcal								
68	ificate g phy as the	edic								
Вох	death certifical attending place as t	M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy				23d	Date of delivery	,
m	death a atte	Physiclan/M	in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pre 5 ☐ Other (spe			250.		ay Year
0	by the destached	ys	9 Unknown	9□ Unknown						
σ.	s that		Part II. Other significant conditions con	tributing to death but not resulting in	the underlying ca	use given in Part	I. 23e. Did	tobacco use o	contribute to the	cause of death?
Records,	quires n sign ald be	d by					1 🗆	Yes ZXON	o 3 Probat	oly 4 □Unknown
		Completed					24a. Wa	200	th Warn nutane	findings available
Re	The law cate has b page 2 sl	Ę.					auto		prior to comp death?	by findings available oletion of cause of
		CO	25. Was case referred to medical				1 ☐ Yes	2 <b>X</b> ) No		□No
Ē		0 8	examiner?	ospital:	20.00	Other	e of Death (Check only	Section 1		
	r this aral di	-	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. T		17.	ursing Home 5 Res			
Division	th. After funer	후	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		njury M	c. Injury at Work? 1 Yes 2			<b>54</b> 11 <b>5</b> 4	
/İSİ	al or Attending after death. I Diractor: After d in by the funer	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, far				(Street and Nu	ımber or Rural F	Route Number
É	r i fe c	Certification;	4 Homicide	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State)		Touto Trambon,
	To the Hospital within 24 hours a To the Funeral D completely filled i	_	29a. Certifier 1X Certifying Phys	icien: To the best of my knowledge	. death occurred a	t the time, date ar	nd place, and due to the	rause(s) and	manner as stat	ed.
	24 Pu 1 24 Pu 19 Fu 19telly	Medica	(Check only 2 Medical Examination)	er: On the basis of examination and and manner stated.	Vor investigation,	in my opinion, dea	ath occurred at the time	date and place	ce, and due to the	ne cause(s)
	ro th within Fo th	¥	29b. Signature and title of certifier	/	29c.	License number		29d. Date sig	ned (Month, Da	iy, Year)
	-,-0		I dell THE			D005560/				
1	V	+	30. Name and address of person who co	npleted cause of death (Item 23a) (		D0055694		Мау	2, 2005	
,			Alok Mathur, M.			le Road	Olney Mar	brelva	20832	
	Sta	e	31. Date filed (Month, Day, Year)	32. Pegistrar's Signature	Acare De	_o noau,	Ourrey, rial	утани	20032	
	Registra	ar	MAY 0 5 20	32. flegistrar's Signature	C. T. C. C.					

			1- State of Maryland / Dep	eartment of Health and Mertificate of Death		iene () ()	5 16964
ı	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Deat Month		3. Time of Death
	/Medic		MARTHA EVELYN LEWIS			6, 20	
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of	
			CUPPETT & WEEKS NURSING HOME  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	OAKLAND If Under 1 Year If Under 24 Hrs.		GARRE'	
	Funeral Director		218-12-5025 1 M 2 M F 83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, SEPT 17,	<sup>Year)</sup> 1921	9. Birthplace (State or Foreign Country) MARYLAND
			Usual Residence of Decedent		JEL 1/9	1921	HARTBAND
	nylan show	_	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Ba-f	Director	MD GARRETT OAKLAND				1 ☐ Yes 2 No
	with ti	D	100. Street and Number	10f. Zip Code		g. Citizen of Wi	hat Country?
	eath	erai	13917 GARRETT HIGHWAY  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispania Origina (Spe		USA	
336	within 72 hours after death with the Maryland jiene. rthen "neturel", or Items 23e or 28e-f show the Medical Evantirer must be notified at	by Funerai	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I  ☐ Yes 2 No Specify:	Rican, etc.)	Black	- American Indian, , White, etc. WHITE
21215-0036	72 ho 'netur	Completed		dent's Usual Occupation	1	6b. Kind of Bus	iness/industry
2	within 7 ene. than "c	npie	Elementary/Secondary (0-12) College (1-4or 5+)	s kind of work done during most of workir DO NOT use retired)	_		
	e filed within at Hygiene. other than vent, the Me			ES CLERK			CLOTHING
Maryland		o Be	17. Father's Name (First, Middle, Last) WILLIAM WALTER LEWIS	18. Mother's Name  LILLIE M			)
Ž	es 1 and 2 should b of Health and Ments litem 27 is marked r other treumatic e	To		ng Address (Street and Number or Rura			tate Zin Codel
	nd 2 alth a 27 is				KLAND, 1		
altimore,	of Her of Her item		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)	ate 2	0c. Location - C	ity or Town, State
Ĕ	Page nent ant: If ury or		Durial 2 Contration 3 Chemiovas from State	CEMETERY 5/9/0	05 0	AKLAND,	MARYLAND
Balt	permit. Pages 1 Department of H Important: If its any njury or ot			2. Name and Address of Facility DURST FUNERAL HOME		BOX 243 ND, MD	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arres	st,	Approximate Interval Between
ļ	Pnysician		Immediate Cause (Final disease or condition				Onset and Death
П	/Medical Examiner		resulting in death)  Due to or as a consequence of:				T
		-	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):			_	Jyears
Т	nsit	nin	Cause (Disease or injury				
Ć,	execu n and ial-tra	Examiner	that initiated events c c				
8760,	cate be executed physician and the burial-transit	dicai	d				
9	ng ph	a)	IF FEMALE:				
Вох	leath certifi attending p I for use as	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of	
O.	The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	Other (specify)		Month	n Day Year
<b>Q</b>	that the ed by detac	P.	Par II. Other significent conditions contributing to death but not resulting in the u	nderlying cause given in Part I	23e Did toba	cco use contribu	ute to the cause of death?
Vital Records,	w requires to been signer should be	d by	Metrothymidism hyperlexidence	, hungertealier	1 □ Yes	1-/	☐ Probably 4 ☐Unknown
OS	w req	ete		1010	24a. Was an	24h Wa	re autopsy findings available
Be	The law te has age 2 :	Completed			autopsy performe	od2 dea	or to completion of cause of ath?
ital	ysicien: The is certificate hadrector, page	e e	25. Was case referred to medical	26. Place of Death		No 1L	Yes 2□ No
	Physicien: r this certifice ral director, p	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Other - /		ce 6 Other	(Specify)
0	tending Ph leath. tor: After th the funeral		27. Manner of Sath 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		d. Describe how		
Sio	Attending or death. ector: After by the fune	cati	Accident investigation  3 Suicide 6 Could not be	M 1 Yes 2 No			
Division of	after death after death Director: In by the	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)	eet, factory, office 28	City or Town,		or Rural Route Number,
_	spita nours nerel		29a. Certifier Check cott. (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Check cott.) (Ch	1 Occurred at the time, date and place, an	d due to the cau	se(s) and mach	er as stated
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	(Check only one) Medicel Exeminer: On the basis of examination and/or invane)	estigation, in my opinion, death occurred	d at the time, date	and place, and	due to the cause(s)
	To t To tl	X	29b. Signature and title of certifier	29c. License number		_	Month, Day, Year)
	-2-		Marganet a Kaine 11	D 26650		5-6-2	2005
	2		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 4 (1/1/1)	M	00. 1	1005 101 2155D
	0		Margaret a Kaiser und 130 31. Date filed Month, Day, Year) 32. Registrar's Signature	71 Hawett Highwa	y Was	reand, i	NU 24550
	Stat Registra		31. Date filed Month, Day, Year) 9 2005	Conte	•		

	•	1 - For State Registrar	_ ,	•	partment of F e <i>rtificate of</i> a			Rag. No. 0 0 5	16965
		Decedent's Name (First, Middle, I	Last)				2. Date of Dea		3. Time of Death
Physicia /Medic		Vivi	an Lorrain	e Machos	skie		MAY	2 2005	10:17 A M
Examin		4a. Facility Name (If not institution, g		- 7		r Location of Deat	h	4c. County of De	
		Doctor's Commu		a⊥ a (In yrs. last birthda		nham If Under 24 Hrs		h 9. B	George's
Funeral Director		577-46-1089	1 □ M 2 🔀 F	70 Yrs.	Months Days	Hours Min.		y, Year)	Shington DC
pu >		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or	Location			, = , 0 1 1 1 1 0	10d. Inside City Limits
Aaryia I shov	ō		George's	Too. Oily, Town of		rrollton			1 Types 2 No
after death with the Maryland or Items 23e or 28e-f show reit et inset be rediffed at	Director	10e. Street and Number	colige 5		10f. Zip Code	LIOII		10g. Citizen of What	Country?
h with		5902 89th Ave	enue		20	0784		USA	
er death w Items 23e	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?	ever in U.S. 1	3. Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
ours after dec rel', or Items Ereni et In	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	lo	1 ☐ Yes 2X No	Specify:		Specify:	1. 4. 4. 0.
turel		15. Decedent's	Education		cedent's Usual Occup			16b. Kind of Busines	hite ss/Industry
hin 72 e. en "ne Medil	Completed	(Specify only highest ( Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	life	ive kind of work done a. DO NOT use retired	during most of wo 1)	rking		
ed wit ygient yer th	Соп	12th			Clerical		(F)	Gover	nment
I be fill ntal H ed oth	Be	17. Father's Name (First, Middle, La Edward Booth	•				me (First, Middie, elen Hirs	Maiden Sumame)	
should nd Me mark metic	ပ္	19a. Informant's Name/Relationship		19b. Ma	ailing Address (Street			er, City or Town, State	, Zip Code)
alth ar 27 is		John Machoskie	(Husband)	590	2 89th Ave	enue, Nev	v Carroll	Lton, MD 2	0784
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If idem 27 is marked other then "neturel", any injury or other treumetic event, the Medical Exagnose.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	3. □Removal from State	cemetery, c	sposition (Name of trematory or other plac		Date	20c. Location - City	or Town, State
Pag ment tent: I		' 4 □ Donation 5 □ Other (Spe	ecify)	Chesape	ake Cremat		2005	Beltsvill	Le, MD
permit Depar Impor any in once.		21. Signatur of Funeral Service Lic	censee	_	22. Name and Addre	110		le Funeral	
		23a, Part1. Enter the disease, or or	omplications that caused	the death. Do not				am MD 2070 rest,	Approximate
Physician	_	shock, or heart tailure List or Immediate Cause (Final	nly one cause on each lir		ORESPIR	05001	·/\:(0,0).	205	Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	OKE STIK	HIORY	MARRI	531	
Examiner		Sequentially list conditions,			RY ARS	ERY "	SISCAS	E	
ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
executed and al-transit	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
			d						
The law requires that the death certificate be safe has been signed by the attending physiciar bage 2 should be detached for use as the buri	Physician/Medical	IF FEMALE:							
ath ce ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal death	3 Ectopic pregnancy	,		23d. Date of o	lelivery Day Year
that the death ed by the atte detached for	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5 Other (specify) _				•
that the		Part II. Other significant condition	s contributing to death be	ut not resulting in the	e underlying cause grv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
quires n signe	d by	PERIPI	+ ERAL	VASCUL	AR DIS	EASE	1 🗆 Y	′es 2□No 3□	Probably 4 Unknown
aw requir s been si 2 should	Completed						24a. Was a		autopsy findings available o completion of cause of
The lav	Com						perfo/	rmed? death	?
L tag	Be (	25. Was case referred to medical examiner?	l tta itali		011		ath (Check only or	пе)	
	-	1 Yes 2 No	Hospital: 1 ☐ Inpatie			4 🗀 (4u) Siriy 1		lence 6 Other (Sp.	pecify)
ysicien: is certifica director, p	To		(Month, Day		y Wor	k? Yes 2 □ No	200. 2000.00	1,017 00001.00	
g Physicien: er this certifica eral director, p	⊢	1. Natural 5 ☐ Pending	tion						
g Physicien: er this certifica eral director, p	⊢	2 Accident investigat 3 Suicide 6 Could no	ot be 28e. Place of Inju	ury - At home, farm,	street, factory, office				Rural Route Number,
g Physicien: er this certifica eral director, p	ertification; T	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could no	ot be and Black of Init	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Tow		Rural Route Number,
g Physicien: er this certifica eral director, p	Certification; T	2 Accident 3 Suicide 4 Homicide  29a. Certifler (Check only 2 Medical Ex	28e. Place of Injuding, etc	c. (Specify)  of my knowledge, de examination and/or	eath occurred at the tir	ne, date and place	City or Tow	m, State) cause(s) and manner	as stated.
Physicien: this certifica ral director, p	ertification; T	2 Accident investiga 3 Suicide 6 Could no determin	28e. Place of Injudent Design of Physician: To the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the bes	c. (Specify)  of my knowledge, de examination and/or	eath occurred at the tir	pinion, death occi	e, and due to the curred at the time, c	m, State) cause(s) and manner	as stated. ue to the cause(s)

Registrar DHMH 17 Rev 1/2001

State

MUTTATH 4203 QUEENSBURY RD. IAYATTSVILLE MD 20181

5 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESHKUWAR 31. Date filed (Month, Day, Year)

MAY 0 6 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Eusebia J. Miguelino 2005 April 30. 1:10A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friends House Sandy Spring

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Director 576-32-2093 89 22, 1916 Philippines Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It is Medical Examinar must be notified at Director 1 ☐ Yes 2 ▼ No Maryland Howard Fulton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11296 Scaggsville Rd 20759 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify. 3 ☐Widowed 4 ☐ Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicolas Jocson Eusebia Yuvienco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E.J. Miguelino/Son 1309 Spencerville Rd, Spencerville, MD 20868 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Jun 1, 2005 Arlington, VA 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Onge 5 Vear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dran Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical ears IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, b 1 🔲 Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has 2₽No 2 No 1 ☐ Yes 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man r of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. I Director: After I Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 43237 any 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PK. Dr. #102 Laurel, mo 20707 14201 PAUL ARMSTRONG MO Lucel 32. pegistrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 5 2005 Registrar

MLN 05-03027 David Maruszak

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 1740 **Physician** May 2005 MARUSZAK DAVID /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's <u>Ridge</u> 13655 Evergreen Estates Lane Birthplace (State or Foreign Country)
 OHIO 8. Date of Birth (Month, Day, Year) FEB. 10, 1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1[XM 2□ F Yrs 26 299-80-1056 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 10a State or 28e-f show treumatic event, the Madical Exeminer must be notified at 1 X Yes 2 ☐ No NORTH ROYALTON OHTO **CUYAHOGA** Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 44133 U.S.A. Items 23a 9901 RIDGE RD. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No1999-If Yes, Give Year or Dates: 2005 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🖫 No Specify: Specify: 9 2005 WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) then " College (1-4or 5+) Elementary/Secondary (0-12) DEFENSE U.S. NAVY 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fil ment of Health and Mental H ient: If item 27 Is marked ott SZCZEPANSKI ANTOINETTE MARUSZAK FLORIAN ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9901 RIDGE RD., NORTH ROYALTON, OHIO 44133 MARUSZAK/FATHER FLORIAN y or other t 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition OHIO WESTERN RESERVE 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Importent: If any injury or once. 5-9-2005 RITTMAN, OHIO NATIONAL CEM. 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
RIVERDALE, MD. 20737 21. Signature of Funeral Service Lidensee MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. gunshot Contact Immediate Cause (Final wound Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death P.O. I ed by the a detached 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t by Records. 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☑ Yes 2 ☐ No 1 X Yes 2 No Division of Vital 26. Place of Death Check on one Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6  $\Sigma$ Other (Specify) Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 X Yes 2 □ No 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death After Certification Injury Shot lumse It subject 5 Pending investigation 1 Natural Found 17:33 PM 1 ☐ Yes 2 No after death. 5-1-05 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 13.555 EVERGREEN 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Homicide At home Estates Lane, Ridge 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier The Certifying Prinyacient to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 XI Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May, 2, 2005 OCME hi min 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 LI LING 31. Date filed (Month, Day, Year)

State Registrar

MAY 05 2005



State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Lest) Physician Dri HERBERT E. MAAS /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner LAYHILL NURSING CENTER SILVER SPRING ar If Under 24 Hrs. 8. Date MONTGOMERY If Under 1 Year 5. Social Security Number 7. Age (In vrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days Min 1 X M 2 □ F 059-09-7107 91 Director MARCH 31, 1914NEW YORK Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23e or 28s-f show other traumatic event, the Madical Examinar must be notified at 1X Yes 2 □ No Directo MARYLAND MONTGOMERY SILVER SPRING 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 3310 N. LEISURE WORLD BLVD. #320 by Funerai 20906 U.S.A. 12. Was Decedent Ever in U,S.
Armed Forces?
1 X Yes 2 □ No
1 Yes, Give
Year or Detes: 1941-42 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced WHITE Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry NEW YORK 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 end 2 should be filled within Depertment of Health and Mantal Hygiene. Important: if item 27 is marked other than any injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) DIVISION HOUSING REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EMIL MAAS LEVY 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DOUGLAS E. MAAS/SON 15209 WATERGATE RD., SILVER SPRING, MD 20905
Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremetion 3 ☑ Removal from State 20b. Place of Disposition (Neme of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) MT. NEBOH CEMETERY 5/3/05 QUEENS, NEW YORK 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service Licensee ranala 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examiner is certificata has been signed by the attending physicien and director, page 2 should be detached for use es the buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or as a consequence of) Part II. Other significant conditione contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 🖾 No 1 🗌 Yes 2 📈 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funaral director, 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 1 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 20 No 1 Inpatient 3□ DOA 2 ER/Outpatient 28d. Describe how injury occurred 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature en the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 1704 31. Date filed (Month, Day, Year) 32 Registrer's Signature State 05 Registrar

			1- State of Maryland / Department of Health and Certificate of Death	Mental F	lygie Reg	$\angle UU$	15	15969
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	/Medic Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	14 A 62.	1	28 2 4c. County	005 of Death	Ø.70 ···
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	s. 8. Date of	Birth Day, Ye	aar)		lace (State or Foreign try)
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Š	d 2 ith au th au trau		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Michael A. Musselman/Son  19b. Mailing Address ( <i>Street and Number or Ri</i> 464 Cedar Haven Road	dural Route Nur , Arnol	nber, C	ity or Town, S VID 21	State, Zip 012	Code)
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Ĕ	Pages ment of ant: If it ury or o		1   Burial 2 □ Cremation 3 □ Removal from State  Glen Haven cemetery  A □ Donation 5 □ Other (Specify)  May	7 2 <b>,</b> 2005	Gl	en Bur	nie,	MD
Baltimore,	permit. Pages 1 Department of H Important: If ital any injury or ott		21. Sign are 39 ineral Service Licensee.  22. Name and Address of Facility Barranco & Sons, I 495 Gov. Ritchie I	P.A. Se Hwy, Se	veri veri	na Parl na Parl	k Fur k, MI	neral Home 21146
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0	nding th. :: Afte e fune	atlon	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	200. Describ	O HOW II	njury occurre	u	
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or 7			r or Rural	Route Number,
	ne Hospit n 24 hour ne Funare pletely fille	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to th urred at the time	e, date	e(s) and man and place, ar	ner as sta nd due to	ited. the cause(s)
	Vithi To th	ž	29b/ Signature and title of certifier 29c. License number		29d.	Date signed	(Month, D	ay, Year)
			(X ) 4X2 (W) 3/13	51	#4	histo	250	2005
			38. Name and address of person who colleted cause of death (Item 23a) (Type, Print)	o CH	0 - 0	Dian	art	210(0)
	Sta		31. Date filed (Month, Day, Year) Registrar's Signature	101	<u>en</u> J	MIN	ch ac	-(00)
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** 6:000M 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 17 9. Birthplace (State or Foreign MD 5. Social Security Number 6 SAX 7. Age (In vrs. last birthday **Funeral** Year) Months 1 M 3 F 1935 217-30-6462 69 Director Usual Residence of Decedent Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 28a-f ehow traumatic event, the Medical Evar instrings be notified at Middletown MD Frederick 1 XYes 2 ☐ No Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 21769 340 S. USA jefferson St. 230 Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "naturel", or Items 23 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. I ∏Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary $1^{(0-12)}$ College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0'Neal Frances Routzahn Elmer R. ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3823 Crow Rock Rd., Myersville, MD 21773 19a. Informant's Name/Relationship (Type, Print) Charles Smith (Son) item 27 other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If it any injury or of Reformed Cemetery 5/7/05 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Middletown, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup>Donal dre Bo Thompson Funeral Home 31 E. Main St., Middletown, MD Signature of Frineral Arvice Licen 21769 23a. Part1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of early line. Approximate Interval Between Onset and Death 2 Immediate Cause (Final Physician 1 disease or condition resulting in death) /Medical quence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physiclan/Medical Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ь in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by page 2 should be Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitali 2 No Other: npatient 1 Tyes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 🗒 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funerel L pellil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely

State Registrar 29b. Signature and title of certifig

31. Date filed (Month, Day, Yea

DHMH 17 Rev 1/2001

s Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

2005

32. Registr

29c. License number

29d, Date signed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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			> TIMIL	Somi	ma	MI	ا دِ	0002	25759		May 5,	2005		
		;	30. Name and address of person w											
			Walter K. Nauma	ann. M.D.,			Acci	lent	MD 2152	200				
	State		31. Date filed (Month, Per, Yeer)	2005 32. Re	gistrar's Signa	ature								

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Amend item 5 per 3 State of Marylan	d / Department of F	lealth and Me	ental Hygien	enni

1 - Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year May 10. 2005 Emelia N/M/NMalatesta 7:26  $P^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 45086 LIGHTHOUSE ROAD MARY'S PINEY POINT
If Under 1 Year | If Under 24 Hrs. 5210 Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2/CDF Days Hours Min Yrs. Director 91 <del>247-</del>80-2252 NOV.8,1913 ITALY Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2/☐No Director MARYLAND ST. MARY'S PINEY POINT 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 45086 LIGHTHOUSE ROAD 20674 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental LUIGI DILENE TERESA MERCURIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY MALATESTA-NEPHEW 8405 PERRY PL., LA PLATA, other 1 MD altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages ō <u>=</u> 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If any injury or once. ·4 □Donation 5 NOther (Specify) ENTOMBMENT FT.LINCOLN CEM. 5-16-05 BRENTWOOD, MARYLAND M00479 . Name and Address of Facility RAYMOND FUNERAL SERVICE, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20646 Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAL ARREST Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): onjestive Iteart failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Coronary Insufficiary Hyperausion, certificate be executed anding physicien and use as the burial-transli Due to (or as a consequence of): MI Inforct on Old Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 2 No this 28a. Date of Injury (Month, Day Year) Certification: 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the To the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 51 05 30. Name and accress of person who completed cause of death (Item 23a) (Type, Print) Vinod K. Shah, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636 31. Date filed (Month, Av., Year) State Registrar

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Marylo			19a. Informant's Name/Relations			1	ng Address (Street ar			_	vn, State, Zij	p Code)
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Baltimore, permit. Pages 1 an Department of Heal Important: If item 2	DC8		21. Signature of Funeral Service	Licensee	1	100	2. Name and Address	of Facility R.	T. Foard	Fune	ral Ho	ome, P.A.
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DIVISION Of VITA To the Hospital or Attanding Physician: within 24 hours after death to the Funestal Director. After this certific	60	Medical	(Check only 2 Medicel	Examiner: On the	basis of examina	owledge, dea ation and/or in	th occurred at the time	e, date and place, inion, death occur	, and due to the ca rred at the time, da	use(s) and ite and plac	manner as : e, and due t	stated. to the cause(s)
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4	1		30. Name and address of person				Print) Josep		idner, Jr	., MD		
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Reg	gistra		MAY - 6 2	005	Registrar's Sign	for	G.					

State of Maryland / Department of Health and Mental Hygiene) 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2005 PETER PAUL JOHN 8:30 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SUBURBAN HOSPITAL MONTGOMERY BETHESDA 8. Date of Birth (Month, Day, Ye JULY 30, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** County, 1921 WASHINGTON, DC Months Days Hours Min 1**X** M 2□ F Yrs. 83 Director 577-26-5853 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show 1 ☐ Yes 2 ▼No Director GERMANTOWN MD MONTGOMERY the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12102 BRITTANIA CIRCLE 20874 USA Funera 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No ARMY If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: WWII WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. Ih and Mentał Hygiene. 7 Is marked other than "nu Elementary/Secondary (0-12) College (1-4or 5+) MANAGER RESTAURANT permit, Pages 1 and 2 should be filed w
Department of Health and Mentat Hygies
Importent: If item 27 is marked other ti
any injury or other traumatic event, its
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN PETER PAUL POTAT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 AKERS DRIVE MOUNT AIRY, MARYLAND 21771 GEORGE T. PAUL - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State FORT LINCOLN CEMETERY MAY 6,2005 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Juneral Service 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS 4 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** UTI UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): the attending physician ched for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ACUTE RENAL FAILURE 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 X No 1 ☐ Yes 2XINo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 XNatural investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061631 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DR. ROCKVILLE, MD 20850 NATASHA LISA CHEN, M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 05 2005 Registrar

DHMH 17 Rev 1/2001

PETER PAUL

			State of Maryland / Department of Health and Mental Hygiene
		•	1- For State Registrar Certificate of Death Reg. No. 159/5
ď	DI		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year  3. Time of Death
	Physicia /Medic		James Franklin Pfister May 11 2005 1527 M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Frostburg Village Nursing Home Frostburg  4c. County of Death  Allegany
П	Funeral Director		5. Social Security Number 219-14-6311 6. Sex 11 M 2 F 81 7. Age (In yrs. last birthday) 12 F 81 15 Months 16 Under 1 Year 17 Months 18 Days 19 Hours 19 June 19, 1923 19 Maryland 9. Birthplace (State or Foreign Country) 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Months 19 Mont
	pu ,		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
	laryla show	ō	Maryland Allegany Cumberland 1□Yes 💯 No
	the N	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	hours after death with the Maryland turel', or Iteme 23a or 28a-f show at Examinat must be notified at		13912 Craddock Road 21502 USA
	deat	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
36	s after, or It	by Fu	1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White
21215-0036	s within 72 hours after death with the Marylan tiene. I then "naturel", or iteme 23a or 28a-1 show The Madical Examinat mast be notified at	ed b	3 Wildowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
215	within 72 ene. then "nat	plet	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)
	filed withir Hygiene. other then ant, the M	Completed	12 Construction Worker Construction
nd	ed fall	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  Nonnio Elizaboth Chomes
Maryland	d 2 should be th and Mental t7 Is marked c traumatic eve	P	George Pfister  Nannie Elizabeth Cherry  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Z	12:4 har 7 Is		Harold Pfister-Brother 13912 Craddock Road Cumberland, MD 21502
re,	- I 6 -		20a. Method of Disposition  20b. Place of Disposition (Name of Disposition (Name of Date Date Date Date Date Date Date Date
<u>m</u>	nit. Pages partment of lortent; If its injury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Silbaugh Crematory May 13,2005 Uniontown, PA
Baltimore,	permit. Page Department of Importent; If eny injury or once.	1	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Hafer Funeral Service, PA
_		$\Box$	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  215.02  Approximate Interval Between Onset and Death
			shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death  Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Acute Massive Myo Carrelal Infavolution (O mixilg
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Acute Massive Myo Carrhad Imfavchini (O minilg Due to (or as a consequence of):  Sequentially list conditions.  b. Covenary attagosclerosis 30 years
1/	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
¥ .	be executed sician and burial-transit	Examine	resulting in death) Last  Due to (or as a consequence of):
,09/	te be e iysician ne buris	cai E	d
68			
Вох	death certifica e attending ph od for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivery Month Day Year
.O.	ne dea the at thed fo	Physician/Med	1 Pegnant at time of death 5 Other (specify) 9 Unknown
<u>α</u>	The law requires that the de ate has been signed by the a bage 2 should be detached i		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
rds,	w requires been signi should be	d by	Diabetes wellits. Congestive heart Failure 1 Yes 2 No 3 Probably 4 DUNKnown
900	aw rec is bee 2 sho	Completed	Hyperten Sion COPD Employ Jama . 24a. Was an autopsy findings available prior to completion of cause of
R		mo/	performed? death?  1 \( \text{Yes} 2 \( \text{QNo} \) \( 1 \) \( \text{Yes} 2 \) \( \text{No} \)
/ita	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner? Hospital:
of	Phys this ral dii	- To	1   Inpatient 2   EH/Outpatient 3   DOA 4   DVNursing Home 5   Hesidence 6   Other (Specify)
on	ding P th: After s funer	tion	27. Mannyr of Death  28a. Date of Injury 28b. Time of Injury 28b. Time of Work? 2 Accident investigation  28d. Describe how injury occurred Work? 1 Yes 2 No
Division of Vital Record	Atter ar dea ector by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)
۵	itel or rrs afte ral Dir led in		
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	o the	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	- s + ö		) Sandhur Mid D14464 05-11-2005
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	2		Dr. S. L. Sandhir 48 Tarn terr, Frostburg MD 21532
	Sta Registi		31. Date filed (Mooth, Day, Year) MAY 1 8 2005  A. Registrar's Signature

		FUI	artment of Health and Mental Hygie	ne
		1. Decedent's Name (First, Middle, Last)	ertificate of Death Reg.	No. 3. Time of Death
Physici	an	MARY VIOLA PROCTOR		Day Year 7:25P M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LXamii		8325 MARSHALL CORNER ROAD	POMFRET	CHARLES
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min. (Month, Day, Ye	9. Birthplace (State or Foreign Country)
Director	-	214-32-9236 93 Yrs.	APRIL 10	6,1912 MARYLAND
yland		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
a Mar	ctor	MARYLAND CHARLES POMFRET		1 ☐ Yes 2 ☑ No
or 28	Directo	10e. Street and Number		Citizen of What Country?
a 23a	erai	8325 MARSHALL CORNER ROAD  11 Marital Status 12. Was Decedent Ever in U.S. 13.	20675 Was Decedent of Hispanic Origin? (Specify Yes or No-	U.S.A.  14. Race - American Indian,
fter de	Funerai	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
Ind 21215-0036 ba filed within 72 hours after death with the Maryland tial Hygiene. so other then "natural", or Itema 23a or 28a-1 show event, the Marical Examiner rest to molified at	Ď.	MVidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes XIX No Specify:	Specify: BLACK
5-0 72 ho 72 ho	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation  a kind of work done during most of working  DO NOT use retired)	. Kind of Business/Industry
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Hygir Hygir ent,	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maid	
Maryland 212' d 2 should be filed within th and Mental Hygiene. ?? Is marked other than traumatic event, It e M	To B	JOSEPH ROBINSON	CARRIE VIRGINIA	A PROCTOR
aryla 2 should and Men la marke	·	19a. Informant's Name/Relationship (Type, Print)	ling Address (Street and Number or Rural Route Number, Ci	ity or Town, State, Zip Code)
C = 14 F		CAROLYN PROCTOR - DAUGHTER 832  20a. Method of Disposition 20b. Place of Disp	5 MARSHALL CORNER RD., J	POMFRET, MD 20675 c. Location - City or Town, State
0 0		1 ⊠Burial 2 □ Cremation 3 □ Removal from State	ematory or other place)	•
꾸 고등원들 .			22. Name and Address of Facility	OMFRET, MARYLAND
Bal permi Depa Impo any ir		Michael O. Ly	RAYMOND FUNERAL SERVICE  LA PLATA, MARYLAND 2064	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	HEART DISEAS	Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of):		
	ē	Sequentially list conditions, france in the sequence of its any, leading to immediate b. Due to (or as a consequence of):		
d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
8760, cata be executed hysician and the burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):		
I Records, P.O. Box 68760,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d		
X 68 certifica ding pl	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box death cert attendin	ciar	in the past 12 months?  4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
t the c by the	Physician/Med	9 Unknown		
ds, P.O. Box 6i ires that the death certific signad by the attending p doe detached for use as	ру Р	Part II. Other significant conditions contributing to death but not resulting in the	and onlying datase given my and	co use contribute to the cause of death?
Cord  v requir been si	eted		1 ☐ Yes	
Records, the law requires t e has been signs age 2 should be	Completed		24a. Was an autopsy performer	24b. Were autopsy findings available prior to completion of cause of death?
f Vital Reyaician: The lis certificate hadirector, page		25. Was case referred to medical	1 ☐ Yes 2 ☐ 26. Place of Death (Check only one)	And 1 Yes 2 No
Vital yalcian: s certifica	To Be	examiner? 1 Yes 2 Ro  Hospital: 1 Inpatient 2 ER/Outpatie	Other	e 6 Other (Specify)
vision of Vital Attending Physician: r death. setor: After this certifical y the funeral director.		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) Injury		injury occurred
SiOI tendii leath. tor: Ai	catic	2 Accident investigation	M 1 Yes 2 No	at and Number or Rural Route Number,
Division of Attending after death. Director: Afte	Certification;	determined  4 ☐ Homicide  determined  determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	City or Town, S	tate)
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he Ho in 24 in Fu pletel	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or one) and manner stated.		
To 1	Σ	29b. Signature and title of certifier	29c. License number 29d.	Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	3/11/03
2		30. Name and address of person who completed cause of death (item 23a) (Type	lote M 206	646
	ate	31. Date filed Av. Pay Year 32. Registrar's Signature	202	
Regist	rar	Specie It free		

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	. 1000			nd / Depa		Health and I			005	16977
			Decedent's Name (Fire	st, Middle, L	ast)					2. Date of De			3. Time of Death
	Physici		Ann		Ρ.		R-	ichardso	m	Month 1	26	Year	17:50 PM
	/Medio Examin		4a. Facility Name (If not	institution, a		nber)			, or Location of Death	U	4c. Co	unty of Death	
	Examin	er	1	1			Cantra	5.1	. /				
-	F		FENINSULA 5. Social Security Number		na/ Mr	7. Age (In yrs.	last birthday)	If Under 1 Year	Sby (4) ar If Unger 24 Hrs.	8. Date of Bi	dh	CONICE 9 Birth	place (State or Foreign
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	land ow		10a. State 10b	. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
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	28a	ec	10e, Street and Number	Somers	er	Pr	incess	10f. Zip Code			10g. Citizen	of What Cou	intry?
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	after death with the Marylan or itams 23a or 28a-f show	Completed by Funeral Director	30421 Oa	k Stre	12 Was Dece	dent Ever in I	IS 13 1	Mas Decedent of		pecify Yes or N	n 14	Race - Ameri	ican Indian
	itan Tan	Ę	1 Never Married	2□ Married	Armed Fo	rces?	,.0.	f Yes, specify Cu	f Hispanic Origin? (S uban, Mexican, Puert	o Rican, etc.)	´   ```	Black, White	
36	rs aff	y F	3 Widowed 4 □		If Yes, Giv Year or Da	ates:		1⊡Yes 2 <mark>X</mark> N	o Specify:		Spi	ecify: Wh	ite
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2	within 7 piene. r than "n	E	Elementary/Secondar	y (0-12)	College (1 Д	-4or 5+)		eacher	,		Edu	cation	
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			Ed Widdows of 20a. Method of Dispositi	on/Att	orney	20h	11791	SCHPTS	et Avenue.	Prince	ss Anr	ie, MD	21853
Baltimore.	ges t of h ff its or ot		1 ⊠ Burial 2 □ Cr		☐Removal from S								
	men men tant: jury	,	4 □Donation 5 □	/ -		Ве			ery 04/2		Prince	ss Ann	ne, MD
<u></u>	permit Depart Import any in	(	2). Signature of Funery	on lo Lic	ensee		22 H	Name and Add	ress of Facility ineral Hom	ie.			
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ı		1	23a. Part1. Exter the cli shock, or heart fail	sease, or co	mplications that c	aused the dea	th. Do not ent	er the mode of d	ying, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Fina disease or condition		1	acter		20 20 20 40					Onset and Death
	/Medical		resulting in death)	-		or as a consec		2001					nouvi
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1	0.000	e.	Sequentially list condition if any, leading to immed	ons, liate		or as a consec	mency of):	1					1
1,2	uted d ansit	Ē	cause. Enter Underlying Cause (Disease or injur- that initiated events		· in	sulis	2 10	acurin	, dich	efes n	neller	fus	MAGN
1	be executed ician and burial-transit	Examiner	resulting in death) Last		Due to (	or as a consec	quence of):		7	, -			7
260	te be executed ysician and ie burial-transii	cal		•	<b>L</b> d			,					
68					<u> </u>								
Or X	certi nding sse a	Š	IF FEMALE: 23b. Was decedent pre-	anant	23c. If yes, out						23d.	Date of deliv	/erv
% Bo	leath certificat attending phy I for use as th	ciar	in the past 12 more	ths?		irth 2 Feta ant at time of c		Ectopic pregnar Other (specify)				Month	Day Year
Ö	he d the d	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkno			Garar (apoony)					
ž <del>–</del>	that the de ed by the detached	by Physician/Med	Part II. Other significan	t conditions	contributing to de	eath but not res	sulting in the u	nderlying cause of	given in Part I.	23e. Did	tobacco use	contribute to t	the cause of death?
rd son	The law requires that the death certifica te has been signed by the attending ph bage 2 should be detached for use as the		_		-				~	1 🗆	Yes 2	0 3 ☐ Pro	bably 4 Unknown
200	v requii been s should	Completed											
chard	e law has t	npi								24a. Was	psy	prior to co	opsy findings available ompletion of cause of
1 P	(0)	Co								1 Tes	2 No	death?	2 1 No
2 = E	ysician:   is certifical director, p	Be	25. Was case referred to examiner?	o medical					26. Place of Dea	th (Check only	one)		
16.5	8 5	2	1 ☐ Yes 2 ☑ No		Hospital: 1	npatient 2	ER/Outpatier	t 3 DOA	Other: 4 🗌 Nursing H	iome 5 🗆 Res	dence 6	Other (Speci	ify)
nn on of			27. Manner of Death  1 Natural 5	☐ Pending	28a. Date of	of Injury h, Day Year)	28b. Time of		ury at /ork?	28d. Describe	how injury oc	curred	
L o	Attending r death.	atic	2 Accident	investigati	on			M 1	☐ Yes 2 ☐ No				
An	or Attendater death	tific	3 ☐ Suicide 6	Could not determine	d 286. Place	of Injury - At h	iome, farm, str	eet, factory, offic	е		Street and Ni wn, State)	umber or Rur	al Route Number,
ā	pital or At ours after aral Dirac	Certification;				3,					,,		
	e Hospital 24 hours a 8 Funaral I		29a. Certifier 12	Certifying F	hysician: To the	best of my kn	owledge, deat	occurred at the	time, date and place	, and due to the	cause(s) and	manner as	stated.
	To the Hosp within 24 ho To tha Fund completely f	edicai	one)	Modical EX	aminer: On the ba	ner stated.	ation and/or in	vestigation, in my	y opinion, death occu	irea at the time,	uate and pla	ce, and due t	to the cause(s)
	To the within 2 To tha complet	Ž	29b. Signature and title	of certifier	1,				nse number		29d. Date si	gned (Month,	, Day, Year)
			1/6,68	4/4	9/		-	D	005993	1	4/28	105	
			30. Name and address	of person wh	o completed caus	e of death (Ite	m 23a) (Туре,	Print)			//20		
			Charles B	RETT K	6ffma.	UMD	1006	ARROLL	ST. SALI	shunn	McI.		
1	Sta	ite	31. Date filed (Month, D	ay, Year)	32. R	egistrar's Sign	ature	4	St. SA/				
	Registr	rar	M	AY 03	2005	September 1	St.	Comments.					

			1 louse		of Marylan								gible.	
			1 - For State Registrar	Olaic (	or iviary lar.		rtificate					g. No.	05	16979
			1. Decedent's Name (First, Middle, Las	<u> </u>	4						2. Date of Deat	h	Voor	3. Time of Death
	Physicia /Medic		Lillian I. F	Kich?	ter						Month 5	Day 5	2005	350 am
	Examin		4a. Facility Name (If not institution, give				4b. City, To	wn, or L	ocation of	Death		4c. Cou	nty of Death	
			Ellicott City Hea  5. Social Security Number 6. So		Rehab 7. Age (In yrs.	last hirthday)	E11:		t Ci	ty 4 Hrs. 1	9. Date of Righ	Нс	ward	place (State or Foreign
	Funeral Director			M 2 🗗 🖛	7. Age (iii yis. )	Yrs.			Hours	Min.	8. Date of Birth (Month, Day, May 6,	1919	Con	place (State or Foreign ntry) necticut
	0		Usual Residence of Decedent				1							
	show 11 at	-	10a. State 10b. County			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
	28a-f	ecto	MD Howard  10e. Street and Number		EJ	licot	10f. Zip Co	ode			1	On Citizen	of What Cou	
	Sa or	וַם	3004 N. Ridge Roa	d Apt.	402		· ·	1043					ted St	*
,	nours after death with the maryland turel', or Itams 23a or 28a-f show el Examinar must be notified at	Funeral Director	11. Marital Status		edent Ever in U.	S. 13.				in? (Spe	cify Yes or No- Rican, etc.)	14. F	Race - Ameri	can Indian,
و ،	or Its		1 Never Married 2 Married		2 <b>X</b> No		irres, specily 1 ☐ Yes 2 ☑		Specify:	ruellor	rican, etc.)	Spe	Black, White,	
	ural',	d by	3 XWidowed 4 ☐ Divorced	Year or I									W. Business/Ir	hite
9500-61212	witnin 72 ene. than "nai	Completed	15. Decedent's Ed (Specify only highest gra	de completed		(Give	dent's Usual ( kind of work ( DO NOT use )	done du	ring most	of workir	ng	IOD. KING O	Dusinessyir	idustry
7 7	giene.	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	Home	emaker					Owr	n Home	
	be filed within 72 hours after death with the Marylan tall Hygione. Ital Hygione. Ital Hygione. Ital Medical Evanier must be notified at	Be C	17. Father's Name (First, Middle, Last)								(First, Middle, I	Maiden Sum	name)	
<u> </u>		To	George Heimers								dfield			
= (	V 40 - 60		19a. Informant's Name/Relationship (7) Diane Casey/Daugh								i <i>R</i> oute Number			
d)	s 1 and 3 f Health item 27 othar tr		20a. Method of Disposition	CEL	20b. P		osition (Name matory or othe				-		on - City or T	
e .	Pages ent of nt: If i		1 ☐ Burial 2 【A Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		State		remato:			-5-20	005	Catons	ville	, MD
Baltimore,	permit. Pages I Department of H Important: If ite any injury or ot ance.		21. Signature of Funeral Service Licen		M0104									ily FH Inc.
n	80588		Nem Collus	-wge	ζ								City,	MD 21043
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that one cause on	each line			, ,					0	Approximate Interval Between Onset and Death
F	nysician /Medical	11	Immediate Cause (Final disease or condition resulting in death)	a	Atheros		lio C	ard	OVO	ucu	Ular Di	rear	×	
ı	Examiner			Due to	(or as a consequ	uence of):								
L,		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Doe to	(cras a nonseci	aence of):								
	ocuted nd transit	Examiner	Cause (Disease or injury that initiated events	c										
/60,	ate be executed nysician and he burial-transit	EX	resulting in death) Last	Due to	(or as a consequ	uence of):								
-	physicate to be the the the the the the the the the th	dlcal		d										
Box	ine death certificat by the attending phy ached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna							23d.	Date of deliv	ery
ň	dearr e atte sd for	icla	in the past 12 months? 1 ☐ Yes 2 ☑ No		birth 2 Fetal		Ectopic preg Other (speci		_				Month	Day Year
J.	at the de by the stached i	hys	9 Unknown											
<u>.</u>	The law requires that ite has bean signed b page 2 should be dete	by	Part II. Other significant conditions of	ontributing to	death but not resi	ulting in the u	nderlying cau:	se given	in Part I.					the cause of death? bably 4 2 Unknown
Records,	w requires to bean signer should be a	Completed										-		
Hec	ne law has l ge 2 s	ldm									24a. Was a autops perforr	y ned?	prior to co death?	opsy findings available empletion of cause of
		e Co	25. Was case referred to medical						6 Place	of Death	(Check only on		1 🗆 Yes	2 No
>	ysicilis ceri	ToB	examiner? 1 Tyes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA	Other:			ne 5 🗆 Reside		Other (Specia	fy)
0 0	or Attanding Priystclan: ifter death. Diractor: After this certific in by the funeral director.		27. Manner of Death 1. Natural 5 □ Pending	28a. Date (Mo	of Injury oth, Day Year)	28b. Time or Injury	28c	. Injury a Work?			8d. Describe ho	w injury occ	curred	
Division	death. ctor: A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be	_	o of Injuny . At he	ma farm at	M		s 2 N		18f Location (St	reet and Nu	mher or Pur	al Route Number,
<u> </u>		Certification:	4 Homicide determined	build	e of Injury - At ho ling, etc. (Specify	/)	eet, factory, o	MICO			City or Town		IIIDei Or Huri	ar riodie rvalliber,
	purs ours fille		29a. Certifier 1 Certifying Ph	ysician: To th	e best of my kno	wledge, deat	n occurred at	the time,	date and	place, a	nd due to the ca	use(s) and	manner as s	stated.
	ro the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Examone)	and ma	nner stated.									
ı	vithin 2 To the	Σ	29b. Signature and title of certifier	(0			29c. L	icense n	umber	c1	2	Od. Date sig	ned (Month,	Day, Year)
				Olom					- 07	/		1109	D a	UUJ
			29b. Signature and title of certifier  30. Name and address of person who of Camell Sapapallic  31. Date filed (Month. Day, Year)	completed cau - 3 4co	ise of death (Item	123a) (Type, 11 AV Ch	100 B	a /t	mon	C M	ayland	3/2/	3.	
	Sta	ite												
	Registr	rar	MAY 0 6	2005	Elegues	H.	Frank s	1						

				State of Mar	vland / Der	partment of	Health an	d Mental Hyg	iene	
		•	1 - For Stete Registrar	State of Mar		ertificate c			Z 0 0 5	6980
	0	7	Decedent's Name (First, Middle, L.	ast)				2. Date of Dea	th	3. Time of Death
	Physici /Medic		Edwina Will	ing !	Shores			April	26 2005	11:35 AM
	Examin		4a. Fecility Name (If not institution, g			4b. City, Town	n, or Location of E	Death	4c. County of Deal	h
			23437 Deal Isla			Chan			Somerset	
	Funeral		Social Security Number     6.	1 □ M 2 2 F	In yrs. last birthda Yrs.	y) If Under 1 Ye Months Day		Hrs. 8. Date of Birth Min. (Month, Day	y, Year) 9. Birt	hplace (State or Foreign untry)
	Director		213-22-5820 Usual Residence of Decedent		79			01-13-	1926 Mai	yland
	/land		10a. State 10b. County	1	0c. City, Town or	Location				10d. Inside City Limits
	Man a-f sh	tor	MD Somers	e t	Chance					1 XYes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Cod	9		10g. Citizen of What Co	untry?
	23e wi		23437 Deal Islan	nd Road			1821		USA	
	or deg	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	<ol> <li>Was Decedent of If Yes, specify C</li> </ol>	ol Hispanic Origin Juban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit	
20	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Giver Year or Dates:		1 Yes 2 1	No Specify:		Specify:	
212-0030	be filed within 72 hours after death with the Maryland Hygiene.  d other then "naturel", or items 23e or 28e-f show event, Ite Machel Examiner count be notified at	ed t	15. Decedent's		16a. Dec	edent's Usual Oc	cupation		16b. Kind of Business/	ite Industry
2	nin 72 n na	plet	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Gi	e kind of work do DO NOT use rel	ne durina most of	f working .		,
7	d with giene	Completed	11	none	Hom	emaker			Own Home	
		Be (	17. Father's Name (First, Middle, La.	st)			18. Mother's	Name (First, Middle,	Maiden Sumame)	
yland	2 should be filed within and Mental Hygiene. ie marked other then eumatic event, Ibe M.	2	Martin Willing					e Tyler		
Mar	2 sh and iem reum		19a. Informant's Name/Relationship		19b. Ma	iling Address (Stre	eet and Number o	or Rural Route Numbe	r, City or Town, State, 2	Tip Code)
ຜົ	1 and 1 and 1 and 1 and 27 ther t		Darlene Webster, 20a. Method of Disposition	Daughter	20b. Place of Dis	62 Jeffr	ey Lane,		Anne, MD 2 20c. Location - City or	
٥	ages nt of th		1 Buriai 2 ☐ Cremation 3	Removal from State	cemetery, cr	ematory or other	olace)			
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 ie marked any injury or other treumatic ev <u>once</u> .		'4 □Donation 5 □ Other (Special Signature of Funeral Sarvice Lice						Wenona, Ma	ryrand
a C	Department and sany		May LANGE	/ /2	00295	22 Name and Ad Hinman Fi 11673 Sor	uneral H	ome No Princ	ess Anne, 1	m 21052
			23a. Part1. Enter the disease, or co	mplications that caused th						Approximate Interval Between
	Physician		shock, or heart failure. List on Immediate Cause (Final	y one cause of each line.	eel to	1/4216	)			Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a c	consequence of):	/ / · / · / · / ·				
	Examiner		Sequentially list conditions	B. D.M						
	p	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence of):					
	be executed ician and burial-transit	xam	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a c	consequence of:					
/6C	ate be executed hysician and the burial-transit	ical E								
280	death certificate e attending phys d for use as the			L d						
XOR	n certi nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of del	ivery
ň	death e atte	icia	in the past 12 months?	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tin		☐Ectopic pregna ☐ Other (specify,			Month	Day Year
J.	at the by th tache	Physician/Med	9 Unknown	9□ Unknown						
_	The law requires that the death certifica lie has been signed by the attending ph rage 2 should be detached for use as it	Ď	Part II. Other significant conditions	01.	4 0	underlying cause	given in Part I.		bacco use contribute to	
Records,	w require been signal	Completed	0 11	thum		11)10	UTIS.	_ 1 T	es 2. No 3. Pr	obably 4 Unknown
e C	e 2 sl	nple	(2) Hype	densun				24a. Was a autops perfor	in 24b. Were au prior to death?	topsy findings available completion of cause of
_									PNo 1 ☐ Yes	212 No
Vital	Physicien: The law r this certificate has t ral director, page 2 s	o Be	25. Was case referred to medical examiner?	Hospital:	2☐ ED/O:		Othor	Death (Check only or		
o	Phy r this ral di	$\vdash$	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpati	ent 3L DOA	njury at Vork?		ence 6 □Other (Spec ow injury occurred	oify)
0	nding ith: r: Afte e funé	atlon:	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigat		(ear) Injury		Vork? ☐ Yes 2 ☐ No			
Division	Atte	Certificati	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury building, etc. (	- At home, farm,	street, factory, office	C <del>e</del>	28f. Location (S City or Town	treet and Number or Ru	ral Route Number,
5	itel on rs after el Dij	Cer			, , ,					
	To the Hospitel or Attending Phye within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	edical	(Check only 2 Medicel Ex	Physicien: To the best of a aminer: On the basis of ex	kamination and/or	ath occurred at the investigation, in m	time, date and p by opinion, death	place, and due to the coccurred at the time, o	ause(s) and manner as late and place, and due	stated. to the cause(s)
	the the mplet	Med	29b. Signature and title of certifier	and manner state	d.	29c Lice	ense number		9d. Date signed (Monti	Day Year
,	Viti		MAZ				2503	6	4/27/	25
			30. Name and address of person wh	o completed cause of dea	th (Item 23a) (Tvo					
		н	eda. M.D.4 Eas	stern Sta		w. Si	ALISBU	URY, M	10 2180	4
• -	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's						
	Registi	rar	MAY a	3 2005	L. Le					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year SPRAGUL MAY IST. 2005. 11: 20~ /Medical 4a. Facility Name (If not institution, give street and number) HOSP 4b. City, Town, or Location of Death 4c. County of Death Examiner Comm. P.G. GEORGES If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X**M 2□ F Months Days Hours Yrs. 371 Director 77 54 1940 WASH D.C Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, Ihe Mudical Examinar must be multiled at 10d. Inside City Limits 1 Yes 2 □ No Funeral Director MD. MITCHELLVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ONGRESSIONAL 20721 u.S., death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Ilyes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ Specify: BL 3 Widowed 4 Divorced Year or Dates: 64-68 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. Int: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 YEARS YEARS ÓΙ NFORCE MENT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SNYDER SPRAGUE JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad SPRAGUE SON BARRETT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. HARMONY CEM. 5/6/05 LANDOVER 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee THE AND ADDRESS FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. -12TH ST. NE WASH DC 20017. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRAVENTRICULAR Privsician HEMORRHAGE DAYS /Medical Examiner DUBARACHNOID HEMORRHACE 4 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): the attending physician hed for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death Day 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation М after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 55703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL BERHANE CHEVERLY 7510N 3001 DRIVE 31. Date filed (Month, Day, Year) Registrar's Signature MAY 9 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 MARCIA BERNADETTE SMITH MAY 03, 7:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CENTER PRINCE GEORGES CLINTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M XX F Yrs. Director 54 2130 23, 1950 BARBADOS 166 62 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or Itams 23a or 28a-i show Examiner must be notified at XX Yes 2 No MARYLAND BALTIMORE PIKESVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7913 CRISFORD PLACE, #J 21208 death UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itan any injury or other traumatic avant, the Medical Evantral ONCE. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: BLACK Specify: þ 3 Widowed XXDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2YRS. CLAIMS SPECIALIST PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARTIN TUDOR NEREID EVELYN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRANDYWINE, MD 20613 LLOYD EVELYN / BROTHER 14015 DUCKETT ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State • 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL CEM. 5/11/05 SUITLAND, MD 21. Signature of Fundral Service Licenses 22. Name and Address of Eacility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 Part 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final disease or condition resulting in death) BREAST Physician METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) Physic signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate 2 No 1 Yes 2 No 1 Tyes To the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 € No 2 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: within 24 hours after use....
To the Funeral Director; After the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the f 1 Natural 2 Accident Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a, Certifie 🛙 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ξ, D20986 MO 2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PISCATAWAY Rd MARYLAND LINTON 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 0 6 2005 Registrar

			1 - For State AMEND#23a,b,c,c	State of Ma perMD5/13/0	aryland / Depa	artment of H	lealth and i		ene 005	16983
	0		1. Decedent's Name (First, Middle, La					2. Date of Death		3. Time of Death
	Physici /Medi		Miranda Ellen Ste	rn				Month May 02,	Day Year 2005	6:26 P M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat		4c. County of Dea	
			Holy Cross Hospi				Spring		Montgome	ry
С	Funeral Director		5. Social Security Number 6. S	ex 7.Aga □M2ᡚF	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign Duntry) District Columbia
			579-88-7481 Usual Residence of Decedent	Λ	45 Yrs.			02/06/19	60 of C	olumbia let
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	VA Arlingto	n	Arlington	1				1 X Yes 2 ☐ No
	ith th	Director	10e. Street and Number			10f. Zip Code		10g	Citizen of What Co	ountry?
	ath w	ral	5624 North 27th S	treet		22207			U.S.A.	
	er de Items	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
36	irs aff	by F	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 N If Yes, Give Year or Dates:		☐ Yes 2X No	Specify:		Specify: W	
ğ	filed within 72 hours after death with the Maryland Hygiene. Wher than "naturel", or Items 23e or 28e-f show ont, it e Modical Exarifrer must be fortified at	ted	15. Decedent's Ed	ucation	16a Deced	ent's Usual Occup	ation	16	b. Kind of Business	Andustry
215	thin 7 9.	ple	(Specify only highest gra	de completed) College (1-4or 5	(Give	kind of work done of NOT use retired	during most of war	king	b. Iting of business	maustry
7	er th	Completed	, ( )	4	Unk			F	ederal Go	vernment
nd	m -= 4	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, Ma		
$\frac{3}{2}$	should be and Mental I s marked or umatic eve	10	Richard Stern				Helen J			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked any injury or other treumstic events.		19a. Informant's Name/Relationship (7					ral Route Number, C		
ص ب	1 and Health em 27 othar tr		Helen Stern, Mothe	=	20b. Place of Dispos		Road, B	ethesda,		
و	Pages nent of ont: # it		1 ☐ Burial 2 又Cremation 3 ☐		cemetery, crem	atory or other plac			c. Location - City or	
È	artme orten njur		* 4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen		Ft. Linco	Name and Address				Maryland
ñ	permit. Departe Importe any nj		M-M-7	( ) to			_	imple Tril		land 20852
г			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused						Approximate
н	Physician		Immediate Cause (Final disease or condition							Interval Between Onset and Death
	/Medical		resulting in death)		Cancer Pri	eumonia				Days
	Examiner		Sequentially list conditions	b Adult I	Respiratory	Distres	s Syndro	ne		Days
	sit s	ine	Sequentially list conditions, Tarry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated see or		consequence of j.					-
	and J-tran	Examiner	that initiated events resulting in death) Last	C	Fibrosis					Years
g/20	cate be executed physician and the burial-transit	cal E			n Cancer					Months
200	ificate g phys as the	ed		d						MOTITIES
X D	that the death certifi ed by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of deli	verv
	death	sicla	in the past 12 months? 1 ☐ Yes 2 🛣 No	1□Live birth 2 4□Pregnant at t		Ectopic pregnancy Other (specify)			Month	Day Year
r S	at the	hy	9 Unknown	9□ Unknown						
'n	The law requires that ate has been signed boage 2 should be deta	by	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the un	derlying cause give	n in Part I.			the cause of death?
5	requi	eted						1 🗆 Yes	2 X No 3 □ Pro	bably 4 Unknown
necords,	e law has b	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
								performed 1 ☐ Yes 2 💢	? death? No 1 Yes	2 🗆 No
N I G	yeicien: is certifica director, i	o Be	25. Was case referred to medical examiner?	Hospital:		3 DOA Othe		h (Check only one)		
5	Phy ar this aral d	-	1 ☐ Yes 2 🙀 No 27. Manner of Death	28a. Date of Injury	28b. Time of	OL BOX	4 - Hursing Ho	me 5 Residence		ify)
VISION	nding F ath. r: After e funer	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	28c. Injury Work M 1 □ Y	es 2 □No	200. 200. 200 100 1	ijury occurred	
2	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, stree	et, factory, office		28f. Location (Street	and Number or Rui	al Route Number,
5	ital o	Cer		building, etc.	(Specify)			City or Town, St	are)	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funcel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of e and manner state	my knowledge, death examination and/or inve	occurred at the time stigation, in my op	e, date and place, nion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as	stated. to the cause(s)
	Nithin To the	Me	29b. Signature and title of certifie			29c. License			Date signed (Month,	
			* Kam Mc	/						- 371 . 000/
	43	-	30. Name and address of person who co	empleted cause of dea	ath (Item 23a) (Type. P	D476	012	Ma	y 2, 2005	
	(13)		Paul Mackoul, MD,	8218 Wisco	onsin Ave.	#414, Be	thesda. M	Maryland 2	0814	
	Stat Registra	e i	31. Date filed (Month, Day, Year)  MAY 0.5 200	32 Registrar	s Signature	K)				
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			1 - For State Registrar	State of M	laryland	-	artmen rtificat			and M	lental Hy	giene	1005	16	984
	Physici	an	1. Decedent's Name (First, Middle, Li								2. Date of De Month APRIL	Da	y 200 Year		of Death
	/Medic		VIRGINIA C. SYMA  4a. Facility Name (If not institution, gi		-)		4b. City,	Town, or	Location of	of Death	APKIL	29,	2005 County of Dea		:15P м
	LAGITIII	CI	MILLENNIUM HEALT			CION		EWAT					NNE ARU		
	Funeral			Sex 7. A 1 ☐ M 2√2 F	ge (In yrs. la	•	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di FEB. O.	rth ay, Year)	9. Bi	thplace (State ountry) SACHUS	e or Foreign
	Director		026 14 1319 Usual Residence of Decedent	X	85	115.					FEB.U.	5,19	20 MAS	SACHUS	ETTS
	iryland show	_	10a. State 10b. County		10c. City	, Town or Lo	ocation						_		City Limits
	Ba-1 s	Director	MARYLAND   CALVERT		OWI	NGS	1								es 2 PNo
	with t		10e. Street and Number				10f. Zip						izen of What C	,	
	death	Funerai	8441 MEADOWVTEW (	12. Was Decedent	t Ever in U.S	S. 13.	Was Deced	736 Jent of Hi	spanic Ori	gin? (Sp	ecify Yes or No		CED STA'	erican Indian	
99	or ite	y Fui	1 Never Married 2 Married	Armed Forces  1  Yes 2  If Yes, Give	No		n Yes, spec 1 ☐ Yes		n, mexicar Specify:	i, Puerto	Rican, etc.)		Black, Whi		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 ie marked other then "naturel", or Items 23a or 28a-f show or other treumatic event, the Medical Examiner must be notified at	ed by	3 XWidowed 4 □ Divorced  15. Decedent's 8	Year or Dates:			dent's Usua	Λ	ation			16b K	Specify: WH		
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IZ,	2 should and Men ie marke eumatic	은	JOHN CACKOWSKI  19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	na Address	(Street a	CAMI				or Town, State,	Zip Code)	
	1 and 2 s Health ar iem 27 ie		CHARLES W. SYMAN				MEADO						D. 2073		
altimore,	of Head		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [	Demoval from State	1 00	ace of Dispo	sition (Nan	ne of ther place	θ)		Date		ocation - City or		
Ĕ	Z T e a	1	`4 □Donation 5 □ Other (Spec	<del>\$</del> )		STANIS							DEERFIE	LD,MAS	s
Bai	permit. Departm Importa any inju		21. Signature of Fund al Service Lic	(See		)	2. Name an			GEO	RGE P.		AS FUNE		
	-		23a. Part1. Enter the disease, or con	nplications that cause	d the death						D ROAD or respiratory a		GEWATER	Арргохіп	nate
	Prysician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant Cause (Final Grant												
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P.O.		hysi	9 Unknown	9□ Unknown				,,							
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions	contributing to death I	_			ause give	en in Part I.				use contribute t		/
ord	requir	Completed by	Congestive	Heart		ceily					1	Yes 2	∐No 3∐P	robably 4 [	Unknown
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tal	iclen: Th certificate rector, pag	e Co	Renal Insu 25. Was case referred to medical	bbicienc	À				26 Place	of Dooth	1 ☐ Yes	2 1 No		2 □ No	
ί	Physicien: r this certifica ral director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆 E	ER/Outpatier	nt 3 🗆 DC	A Othe	-		_		6 □Other (Spe	ocify)	
Division of Vital Records,	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	2	8c. Injury Work			28d. Describe				
Sio	Attending or death. ector: After by the fune	Certification:	2 Accident investigated 3 Suicide 6 Could not I	De Diago of la	sinne At box	ma farm et	M		/es 2 🗆 l	_	206 Lanation (	Stroot on	d Number or R	ural Cauta M	um ho s
Σ	il or Attendatter death Director: Jin by the	ertif	4 Homicide determined	28e. Place of In building, e	itc. (Specify)	)	eet, ractory	, onice			City or To			urai noule ivi	imber,
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying P	hysician: To the best	t of my know	vledge, deatl	n occurred	at the tim	e, date an	d place,	and due to the	cause(s)	and manner a	s stated.	
	the Holin 24 the Fu	Medical	one)	miner: On the basis of and manner s	ot examinati tated.	on and/or in				th occurr	ed at the time,				
	To To	~	29b. Signature and title of certifier	c . h	- on	A		License	number 506	52			te signed (Moni - 29 -		
			30. Name and address of person who	completed cause of	death (Item	23a) (Tupe					SURA			4005	
			5851- Deale	- 0 -		-	oad						20751.		
	Sta		31. Date filed (Month, Day, Year)	32. gist	trar's Signat		La M	h		· · · · ·				-	
	Registr	ar	MAY 0 3	ZUU5   /	W S	or A									

Amend Block#6 per PHY 5/4/2005 AA County Health De

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

1 - For Registrar	State of Maryland / Department of Health and N  Certificate of Death		1698
1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Deat
Disable C Chal	L	Month Day A Year	44 00

Physician /Medical Examiner

**Funeral** Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinational Department once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Medical Certification; To Be Completed by Physician/Medical Examiner

1 December Name (First Middle Les	· +1					2 Date of Doot	h		2 Time of Dooth
1. Decedent's Name (First, Middle, Las Elizabeth S. Stu						2. Date of Deat Month May	D	2005	3. Time of Death 11:37 a M
4a. Fecility Name (If not institution, give Chesapeake Hospi				own, or Location Linthic			-	nty of Death	rundel
234-54-5091	ex 7. Agu ☐ M 2 ☑ F	80 Yrs.		Year If Und Days Hours	er 24 Hrs. s Min.	8. Date of Birth (Month, Day, Apr. 4,	Year) 1925	9. Birth Co.	place (State or Foreign intry) WV
Usuel Residence of Decedent  10a. State  10b. County  Anne Ar	undel	10c. City, Town or I		lersvil	.le				10d, Inside City Limits 1 ☐ Yes 2 ※No
10e. Street and Number 448 Old Orchard	Circle		10f. Zip C	21108	,	10	0g. Citizen o	of What Cou	intry?
11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ② If Yes, Give Year or Dates:		Was Deceder If Yes, specify	y Cuban, Mexic	can, Puerto	ecify Yes or No- Rican, etc.)		ace - Ameri lack, White Wh	
15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	(Giv	edent's Usual re kind of work DO NOT use	done during m	ost of work	ing	16b. Kind of	Business/Ir Home	
17. Father's Name (First, Middle, Last) Harold Willson	2	<u> </u>	TOTIC	18. <b>M</b> o	ther's Nam	e (First, Middle, N uke	Maiden Suma		<u> </u>
19a. Informant's Name/Relationship (7	Type, Print)	19b. Mai	ling Address (	Street and Nun	nber or Run	al Route Number,	City or Tow	n, State, Zi	p Code)
Janie S. Stevens	on/Daughte				pinete to the	e,Miller	sville	e, MD	21108
20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specify		20b. Place of Disp cemetery, cri Metro C	ematory or other	er place)	May 20	24. 105	20c. Location Baltin		
21. Signature of Funeral Service-Links	3	F	Name and Barranco 195 Gov	Address of Fac Son Ritch	is, P.	A. Sever	na Pai	rk Fu	neral Home D 21146
spock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions,	a. End-	a consequence of):	Emph	y sem	9				Interval Between Onset and Death
if any, leading to immediate  Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetel death 3	□Ectopic preg □ Other (spec					ate of deliv	ery Day Year
Part II. Other significant conditions of Africal Februs	ontributing to death be	ut not resulting in the	underlying cau	se given in Pai	t I.		acco use co s 2 □ No		he cause of death? bably 4 Dunknown
						24a. Was an autopsy perform 1 Yes 2	/	were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of
25. Was case referred to medical examiner?	I to acital.				ce of Deat	h (Check only one	9)		
1 ☐ Yes 2 万No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	nt 2 ER/Outpatie y 28b. Time 'Year) Injury		Other: 4   Injury at Work?		me 5 Resider 28d. Describe hor	X		<sup>(y)</sup> Hospice
3 Suicide 6 Could not be determined		iry - At home, farm, s (Specify)	treet, factory, o	office		28f. Location (Str. City or Town,		nber or Run	al Route Number,
29a. Certifier 1 Certifying Ph. (Check only one)	ysician: To the best of tiner: On the basis of and manner sta	examination and/or i	ath occurred at nvestigation, in	the time, date my opinion, d	and place, eath occurr	and due to the cared at the time, da	use(s) and n te and place	nanner as s o, and due t	itated. o the cause(s)
29b. Signature and title of certifier	mohan	~~ <u></u>		icense numbe	_		od. Date sign		Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

139 Old Solomons Island Rd Annapolis, mis 21401

		1 - For State Registrar	State of Mary	/land /	-	artment of F		nd Mei		giene Reg. No.	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	15986
Physic	ian	1. Decedent's Name (First, Middle, Las	st)	6	EIN	1ER			Date of De Month	Day	Year	3. Time of Death 08 58 p M
/Medi Exami		MARJORIE  4a. Facility Name (If not institution, giv.)	e street and number)		621	4b. City, Town, o	Location of [		MAY	0.1 4c. Co	2005 ounty of Death	- 3 - 3 G p
Lyditii	ici	MARBOR HOSPIT		ER		BALTI	MORE	=				
Funeral		Social Security Number     6. S	ex 7. Age (Ir	yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Bir (Month, Da	th y, Year)	Cour	
Director		213-34-6405 Usual Residence of Decedent	- A	66	113.			0	2/04/1	1939	West	Virginia
iryland thow	_	10a. State 10b. County	10	c. City, To	wn or Lo	cation					1	0d. Inside City Limits
ha Ma 18a-f s	Directo	Maryland Anne Arui	ndel G	len I	Burn					40		1 X Yes 2 No
with the sor 2	Ö	10e. Street and Number 403 West Ordinance	Road Ant	407		10f. Zip Code 21064				USA	n of What Cour	ttry?
"natural", or Itams 23e or 28e-1 show	Funeral	11. Marital Status	12. Was Decedent Ever		13. V	Vas Decedent of H	ispanic Origin	n? (Specify	y Yes or No		Race - Americ	
or Ita		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give			l Tes, specify Cuba	Specify:	ruello Nic	an, etc./		Black, White,	
hours fural	ed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Ed	Year or Dates:	16	a Deced	ient's Usual Occup	ation				Wh:	ite
nin 72	plet	(Specify only highest gra			(Give :	kind of work done	during most o	of working		TOD. KING	01 24311034111	addity
ygiene ygiene t, the	Completed	12		F	lome	Maker				Own H		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Itams 23c or 28a-f show amy nighty or other treatmetic event, the Madreal Express runst be 1 withing all appear.	Be	17. Father's Name (First, Middle, Last) Noah Alden Snuffe					18. Mother's					
should should nd Mer marks	၉	19a. Informant's Name/Relationship		19	b. Mailin	g Address (Street			inia V Ou <i>te Numb</i> e			Code)
nd 2 saith ar 27 is		Michael Selmer/ S	• • • • • • • • • • • • • • • • • • • •			Long Corn				-		,
as 1 a of Hei		20a. Method of Disposition 1 Durial 2 XCremation 3 D		20b. Place cemet	of Dispo:	sition (Name of natory or other place	(e)	Date		20c. Local	tion - City or To	own, State
Pagi ment tent: I		`4 ☐ Donation 5 ☐ Other (Specification )	()	Huntt		ematory		/04/2	-		rf, MD	
permit Depart Import Import any in	ł.	21. Signature of Funeral Service Liver	See			. Name and Addre						al Home
		23a. Part1. Enter the disease, or com	plications that caused the	death. Do	_	or the mode of dyin					20/13	Approximate
Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. RESPIRA  Due to (or as a co	nsequence	e of):	FAILUA		en Co	6 000	SUC 1	Polestandia	Interval Between Onset and Death
ata be exacuted hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence OBS	e of): TRU	CTIVE						
sata be shysici the bu	dlcai	(	d									
auth certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal deal		Ectopic pregnancy Other (specify)				230	I. Date of delive	ery Day Year
v requires that the de been signed by the should be detached		Part II. Other significant conditions of	ontributing to death but no	ot resulting	in the ur	nderlying cause giv	en in Part I.		23e. Did to	obacco use	contribute to the	ne cause of death?
w requires been sign	ed by								1 🗆 🗅	/es 2□N	No 3 Prob	ably 4 Unknown
The taw restate has been page 2 sho	Completed								24a. Was autop perfo 1 Yes	rmed3/	24b. Were auto prior to con death? 1 \(\sum \text{Yes}\)	psy findings available mpletion of cause of
lcien: ector,	Be	25. Was case referred to medical examiner?	Hospital:			0+5	26. Place of					
ding Phys h. After this funeral dir	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		Outpatien Time of Injury	28c, Injur Wor		28d	5 Resid		Other (Specificourred	y)
To the Hospitel or Attending Physicien: The taventhin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not b		At home, Specify)	farm, stre	eet, factory, office		28f.	Location (S City or Tox		lumber or Rura	l Route Number,
ne Hospit n 24 hours ne Funers	Medical (		ysician: To the best of m niner: On the basis of exa and manner stated	amination a								
To t To t	Σ	29b. Signature and title of certifier				29c. Licens					igned (Month,	
		at the same	MD				RES			PAIN	- 01	- 2005
		30. Name and addless of person who NIAN JUNATH M	completed cause of death	(Item 23a ) 3	) (Type, I	Print) SHAN	OUER.	STRE	ET B	ALTIN	noris	1Y10 &1225
St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 3	32. F gistrar's				-	- 0(	• /			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10:15 p M Nathan Ross Selby May 08 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Goodwill Mennonite Home Grantsville Garrett If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 214-32-3558 89 Director Oct.1,1915 Maryland Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Exertinal must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 No 2 No Garrett Friendsville **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 257 Maple Street USA 21531 14 Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: þ 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Timber 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nathan Ernest Selby Lizzie Humberson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1679 Carlyle Dr., Crofton, Maryland Ross J. Selby/Son 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Steele Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) May 13,2005 Friendsville, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee Jeumai P.O. Box 275, Grantsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction 5 weeks /Medical Due to (or as a consequence of): Examiner <u> Athrosclerotic Cardiovascular Disease</u> 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certiticate be executed Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ pe 3 Probably 4 Unknown 1 ☐ Yes 2 € No Dementia, Senile onset Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 1 Yes XXNo To the Hospital or Attanding Physician: tuneral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 📆 No Atter this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours atter death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0025759 05/09/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter Naumann, P.O. Box 247, Accident, Maryland 31. Date filed (Month A Year) 9 2005 32. Resistrar's Signature State Registrar

5-03231 enneth Sharrer

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** May 09, Kenneth Michael Sharrer <u> 2005</u> 1058A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Hancock Washington/Allegany Line-I-68 West If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Yrs. 217-10**-**0546 Director Oct 9. 1919 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits Examine must be notified at Maryland Frederick Frederick 1 X Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 406 Pearl Street 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1943-IfYes, Give Year or Dates: 1946 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ö 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 27 Is marked other then traumatic avent, L. M. College (1-4or 5+) Elementary/Secondary (0-12) Mail Carrier Postal Service 12 Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roy Milton Sharrer Bessie Wills Mary 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 750 White Oak's Avenue, Baltimore, Maryland 21228 Wayne S. Sharrer / Son item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery May 13,2005 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service License Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 106 East Church St, Frederick, Maryland 21701 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 1004 /Medical Due to (or as a consequen ---) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Due to (or as a consequence of): Exam nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): 68760, The law requires that the death certificate be Physiclan/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ sign be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 \[ \subseteq \text{No} \] 24a. Was an certificate has lirector, page 2 s 1X Yes 2 No Vital Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Nother (Specify) (Scene) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1

Yes 2

No ၀ ÷ o 28a. Date of Injury (M + th, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After : 58 motor 1 Natural 5 Pending 1 ☐ Yes 2 No 10 2 Accident investigation 1-00 death. 28f. Location (Street and Number or Rural Route Number, City or Town, State)

WEST A Location (Street and Number or Rural Route Number, City or Town, State) after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 4 | Homicide Hospital or ee Mc within 24 hours a To the Funaral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 10, 2005 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MU111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State MAY 1 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene [] For Stete Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Strite Aden 2005 May 10 3:45 A. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Mennonite Home Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb • 23 191 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 10**X** M 2□ F 92 219-36-4311 Yrs. 1913 Mary land Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show item 27 is marked other than "natural", or items 23e or 28s-f shot other traumatic event, the Medical Examinations to notified at 1 ☐ Yes 2 No Md. Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13436 Maugansville Rd. 21740 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ڄ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien. Important: if item 21 is marked other the any injury or other trauments. Delivery/Set-up Lawn Equipment Co. 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Irvin L. Strite Fannie A. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy L. Martin/Executor 21112 Leiters Mill Rd. Hagerstown, Md. 21742 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Millers Menhonite Church Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/13/05 Leitersburg, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc. 21. Signature of Funeral Service Licensee Marte 17225 45 S. Carlisle St. Greencastle, Pa. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastadic noma Physician astric /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown ate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? res 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification; After 5 Pending investigation Injury 1 Natural To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide completely filled 1 🖔 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) omzzeg 150 x 204 hady brove

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State Registrar 31. Date liled (Monti

legistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 20b, c per In 8843 5-19-05 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 7:45 AM 2005 KEITH SMITH JOSEPH\_ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death APLATA MARYLAND TUnder 1 Year | If Under 24 Hrs. | Ionths Days Hours Min. CHARLES. MEDICAL CENTER ATZIVI 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months XXM 2□ F 55 DEC.4,1948 INDIANA 304-44-9321 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT # 204 20646 HICKORY LANE, U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2♥ XVo Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED 10 PAINTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIAM SMITH HATTIE BURNS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MALINDA FORD-DAUGHTER 8660 LOWELL RD., POMFRET, MD 20b. Place of Disposition (Name of Streemello september place) 20c. Location - City or Town, State **Ponfret** 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State RESURRECTION CEM. 5-18-05 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. Mucha PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one capse on each line. Approximate Interval Betw Immediate Cause (Final 0 bo vo disease or condition resulting in death) consequence of): Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hem officrax IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Xes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

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29a. Certifier

(Check only one)

29b. Signature and little of certifieg

Medical

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

SURGEON

47202

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PRADIP SAHDEY, MD-3450 OLD WASHINGTON RD. SUITE 202 WALDORF MD. 20602

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend, item, 21 per fth, 8843 5-19-05 yt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** May 8, 2005 Stella Agress Twigg 11:15 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 12405 Gramlich Road SW LaVale Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 88 213-22-3253 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Allegany 1 ☐ Yes 2 No LaVale Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 12405 Gramlich Road SW Items 23a 21502 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours efter Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: þ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN AGRESS SOPHIA (TKACHUK) AGRESS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELIA GLASS 12406 Gramlich Road SW, LaVale, MD 21502 If item 27 I Caregiver 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 X Burial 2 □ Cremation 3 □ Removal from State Hillcrest Mem Park May 12 2005 \* 4 Donation 5 ☐ Other (Specify) Cumberland MD 22. Name and Address of Facility Hafer Funeral Service, PA 21. Signature of Funeral Service Licensee Douglas S. Hafer(per dvr) 1302 National Hwy., LaVale, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHRONIC Physician RENAL CAILURE disease or condition resulting in death) y3 years /Medical Due to (or as a consequence of): Examiner MELLITUS DIABETES Sequentially list conditions, flary, leading to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? YERIPHERAL VASCULAR 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No 5 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 🗫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 42054 MAY 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregg Donaldson 912 Seton Dr., Cumberland, MD 21502 31. Date filed (Month, Day, Year) State MAY 1 8 2005 Registrar

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Jar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: It Item 27 is marked other then "natural", or Items 23a or 28a-1 show servicent: It Item 27 is marked other then "natural" or recitized at once.		19a. Informant's Name/Relationship Verlissa Martin-			-	ddress (Street a						
Baltimore, Maryland	t and dealth am 27 ther t		20a. Mathod of Disposition	-washington						ate	20c. Locatio		
סר	Pages nent of h ant: It ite ary or of		1 to Burial 2 ☐ Cremation 3				n (Name of ary or other piace	1					
Ē	it. Partmer rtent rtent njury		<ul><li>4 □ Donation 5 □ Other (Spe</li><li>21. Signature of Fundral Service Light</li></ul>	Α	Harmo		emorial ame and Addres			/2005		dover	-
Ba	permi Deper Impo eny ir		Ann I	Wourdst	TIL		001 Beni						
			23a. Part1. Enter the disease, or co	omplications that cause	d the death. Do r								Approximate
	Pilonatation .		shock, or heart failure. List or Immediate Cause (Final										Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		e Intoxi		on					_	
В	Examiner												
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)	b. Due to (or as	a consequence	of):							
	nd nd transi	Examiner	that initiated events	с.									
Ó,	e exe ien a urial-l	Ex	resulting in death) Last	Due to (or as	a consequence	of):							
8760,	death certificate be executed attending physicien and indice as the burial-transit	dicai		d.				-				-	_
9	seath certific attending pl	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						004	D-1	
Вох	attene for us	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		opic pregnancy her (specify)					Date of deli Month	very Day Year
o.	that the de ed by the detached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	time or death	3 🗆 0 (1	ioi (apecity)						
Δ.	that the		Part II. Other significant condition	s contributing to death t	out not resulting in	the under	lying cause give	n in Part I.		23e. Did t	obacco use c	ontribute lo	the cause of death?
ds	luires I n signe	d by								1 🗆	Yes 2□No	3 🗆 Pro	obably 4 Unknown
CO	w requir s been si should	iete								24a. Was	an 24	b. Were au	topsy findings available
Vital Records,	The law requires that the sate has been signed by the page 2 should be detache	ompieted								autor perfo	psy prmed? 2 \Bo	prior to c death? 1 X Yes	completion of cause of
ta		e C	25. Was case referred to medical			<del></del>		26. Place	of Death	(Check only o		- 133	2010
<u>&gt;</u>	S S D	To B	examiner? 1√XYes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2X ER/Ou	tpatient 3	3□ DOA Othe	er: 4 🗆 Nu	irsing Hon	ne 5 🗆 Resi	dence 6 🗆 0	Other (Spec	cify)
n of	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju		Time of njury	28c. Injury Work	at			how injury occ		
Sio	Attending r death. octor: After by the fune	cati	2 Accident investigat	15-10-05	unk	ζ	M 1 🗆 1	res 2 🟋					
Division	l or Attende efter death Director: I in by the	Certification;	3 ☐ Suicide 6 ☑ Could no 4 ☐ Homicide determine	Dullding, e	jury - At home, fa tc. <i>(Specify)</i>	rm, street,	factory, office		2	8f. Location ( City or To	Street and Nu wn, State) 7	mber or Ru. 822 A	11endale DR
	urs el aral D			Residen		de este				Palmer	Park,	MD	
	Hospitel 24 hours e Funeral I	edicai		Physician: To the best aminer: On the basis of and manner st	of examination an								
	To the Hospital or Attenwithin 24 hours effer deat To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier	A			29c. License				29d. Date sig		
1	p= S  = 0		N O (B)	o Mil)				OCMI	E		MAY 1	1, 20	005
			30. Name and address of person wh	no completed cause of	death (Item 23a)	(Type, Prin	t), D	C.		. 1			1 04004
			J. LAPON 4	OCKE, M	D	11	11 Penn	Stree	et E	saltimo	re, Ma	ryLan	d 21201
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6 2005	32. Regist	rar's Signature								
	11-11-11	12.0				Al.							

			For State Registrar			partment of H ertificate of L			Reg	ene () () [	5 15994
	Dharaini		1. Decedent's Name (First, Middle,	Last)					ite of Death	Day Ye	3. Time of Death
	Physici /Medio		Alvin	Ellsworth	W	RIGHTSMAN		<u>M</u>	ау	8, 200	05 8:30 A M
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of	Death		4c. County of I	Death
			100 Hooker Str	eet			r Park				arrett
	Funeral		5. Social Security Number 6	5. Sex 7. Ag 1 ☑ M 2 ☐ F	ge (In yrs. last birthda	Months Days	If Under 2		te of Birth onth, Day, Y	(ear) 9.	Birthplace (State or Foreign Country)
	Director		212-18-1812	IMI ZUF	83 Yrs.			Ap	r. 12,	1922	Maryland
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	sho sho	č	1000				D 1				1 ☑ Yes 2 ☐ No
	he M	ecto		arrett		Deer 1	Park		100	g. Citizen of Wha	at Country?
	with t	급	10e. Street and Number				1550		100		100
	s 23g	ra	100 Hooker Str	12. Was Decedent	From in U.S.		1550	in? (Considury	os os No	US 14 Bace	American Indian,
	er de Item	n n	11. Marital Status  1 Never Married 2 Married	Armed Forces?	No. S.	<ol><li>Was Decedent of His If Yes, specify Cuba</li></ol>	in, Mexican,	Puerto Rican,	etc.)		White, etc.
36	rs aff	by Funeral Director	3 ⅓Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21亿 No	Specify:			Specify:	White
Ö	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show ha Madical Ezaminar must be notified at	pa	15. Decedent's		16a. Dec	cedent's Usual Occupa	ation		16	b. Kind of Busin	ess/Industry
7	in 72 n "ne	plet	(Specify only highest	grade completed)	(Gi	ve kind of work done o . DO NOT use retired	durina most d	of working			,
7	r the	Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5	5+)	Weld	er			Steel	Fabrication
힏	Hygie other	0	17. Father's Name (First, Middle, La	ast)			18. Mother	's Name (First	Middle, Ma	iden Sumame)	
<u>a</u>	uld be fenta rked ric e	To B	unk				Alma	Fr	ances	Wrig	ghtsman
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other traumatic event. The Mardical Examinar must be notified at once.	-	19a. Informant's Name/Relationship	p (Type, Print)	19b. Ma	iling Address (Street a	and Number	or Rural Rout	e Number, (	City or Town, Sta	ite, Zip Code)
	s 1 and 2 of Health a ltem 27 is		Beverly A. DeB	erry/Daught	er 135	52 Boiling	Sprin	ng Road	, 0ak	land, Md	1. 21550
re	of He		20a. Method of Disposition		cemetery c	position (Name of rematory or other place	e)	Date	20	c. Location - City	y or Town, State
Ĕ	Pages nent of I int: if its		1 ☐ Burial 2 ☑ Cremation 3  `4 ☐ Donation 5 ☐ Other (Spe			Crematory		5/11/05	Me	organtow	n, WV
Baltimore,	mit. Partn Partn Priju		21. Signature of Funeral Service Lin	cen see		22. Name and Addres	s of Facility		32	S. Seco	ond St.
ñ	Department Department of the suny of the suny of the suny of the suny of the suny of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the sun of the		> Blowley	The cook		Stewart F	uneral	L Home	0al	kland, M	ld. 21550
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	d the death. Do not e	enter the mode of dying	g, such as ca	ardiac or resp	ratory arres	t,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition					_			Onset and Death
					3 F 1L #-1 C	RY TA	1641	n E			VOCAVC
	/Medical		resulting in death)		a consequence of):	RY FA	1641	ne			years
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89	Examiner	lan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	Due to (or as b. Due to (or as c. Due to (or as d.  23c. If yes, outcome 1 □ Live birth	a consequence of):  a consequence of):  a consequence of):  of pregnancy 2 ☐ Fetal death	3 ∐Ectopic pregnancy		<i>(E</i>		23d. Date of Month	
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P.O. Box 68	repitel or Attending Physician: The law requires that the death certificate be executed browns after death.  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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			State of Maryland / Department of Health and N  Certificate of Death		Reg. No.	16995
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Ethelyn Louise Warnick	2. Dete of De Month	Dey Year 5 2005	3. Time of Death 8:00 PM
1	/Medic Examin	al	4e Fecility Name (If not institution, give street and number)  4b. City, Town, or Lo		4c. County of Dea	
			120 Hampshire St. Bloomingt  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		Garrett	tholace (State or Foreign
L	Funeral Director		212-24-0511 1 M 2CSF 76 Yrs. Months Days Hours Min.	8. Date of Bir (Month, Da NOV •		thplace (State or Foreign ountry) ryland
	ylend M		Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-f et	Director	MD. Garrett Bloomington			1⊠Yes 2□No
	th with the 23a or 2	ai Dire	10e. Street end Number 120 Hampshire St. 10f. Zip Code 21523		10g. Citizen of What Co United Sta	•
Maryland 21215-0020	be filed within 72 hours aftar deeth with the Maryland and Hygiena. And other than "natural", or items 23a or 28a-f ehow other than "hadical Examinar must be notified at event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No  1 □ Yes 2 ☒ No  1 □ Yes 2 ☒ No  1 □ Yes 2 ☒ No  1 □ Yes 2 ☒ No  1 □ Yes 2 ☒ No  1 □ Yes 2 ☒ No  1 □ Yes 2 ☒ No  1 □ Yes 2 ☒ No		14. Race - Ame Black, Whit Specify: W	e, etc.
15-0	natur	eted	15. Decedent's Education (Specify only highest grede completed)  16a. Decedent's Usuai Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Business	Industry
212	within jiena.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		Housework	
pu	be filed tral Hygi d other event,	Be			Maiden Sumame)	
<u>ryla</u>	should be ind Menta imarked umaric ev	၉	David Gunning McIntyre Tessi  19a. informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run		Hockman  er, City or Town, State,	Zip Code)
Na	aith a 27 is 27 is		Howard Warnick/ son 120 Hampshire St., Blo		n, Maryland	1 21523
Baltimore,	permit. Pages 1 and 2 should Department of Haaith and Men Important: If Item 27 is marke any injury or other traumatic DIGE.		20a. Method of Disposition  1 Description  1 Description  1 Description  20b. Place of Disposition (Name of cemetery, cremetory or other place)  Comparison of Disposition (Name of cemetery, cremetory or other place)  Comparison of Disposition (Name of cemetery, cremetory or other place)  Comparison of Disposition (Name of cemetery, cremetory or other place)	05/09/ 2005	20c. Location - City or Oakland, Ma	
Balt	permit. Pa Departmen important: any injury ptice.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bo		ral Home rt, Marylar	ad 21562
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical	ner	Immediate Cause (Final disease or condition resulting in death)  a. Duq v i a v ( e v w / j Due to (or as a consequence of):	14 m	etastasi	
ő,	ificate be axecuted g physicien end es the burial-trensit	i Examiner	Sequentially list conditions, if erry, leeding to immediate cause. Enter Underlying Cause (Disease or injury c.		h	
	artificate b ing physic e es the b	Medicai	that initiated events resulting in death) Last  Due to (or as a consequence of):			
Вох	attend for us	clan		non Did		to the cause of death?
P.O.	The lew requiras thet tha death can ata has been signed by the attendin pege 2 should be detached for use	Physician/N	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	7577	Yes 2□ No 3□ P	
ds, l	iras the signed d be de	a by		24a Was	an autopsy 24b.	Were autopsy findings
SCOL	s been 2 shoul	Completed by		perfo	rmed?	available prior to completion of cause of death?
<u>~</u>	The le	E S		10	Yes 2/10	1 ☐ Yes 2 ☐ No
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 26. Place of Death examiner? 4 Nursing Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hospital: 1 inpatient 2 ER/Outpatient 3 DOA		one) dence 6 □Other (Spe	oih)
n of	ng Phys Iter this uneral di	on: To	27. Megner of Death (Month, Day Year) 28b. Time of Injury work?  (Month, Day Year) 28b. Time of Injury Work?		how injury occurred	ony)
	or Attending aftar death. Director; After in by tha fune	Certification:	2 Accident	28f. Location (S City or Tol	Street and Number or Rivn, Stete)	ural Route Number,
	Hospi 24 hou Funer staly fill	edical Co	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	and due to the red et the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
1	To the Within 7 To the comple	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mont	h, Day, Year)
	-		Faul Dani Julio H26154		3/6	105
	6		30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Oakland, Md. Dr. P. Daniel Miller, 69 Wolf Acres	21550	(	
	Stat Registra	е	31. Dete filed (Month, Day, Year)  32. Registrer's Signature			

			State of Maryland / Department o  Certificate of	of Death Reg. No. 005 16996
	Physici		1. Decedent's Name (First, Middle, Last)  Edna Muriel Waits	2. Date of Death Month May 4, 2005  Year  2:10 PM
1	/Medic Examir		4a. Fecility Name (If not institution, give street and number)  Goodwill Mennonite Home	4b. City, Town, or Location of Death  Grantsville  Garrett
	Funeral Director		5. Social Security Number 466-24-6953  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Months Da	ear If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	yland Now		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Ba-fet	ctor		rantsville 1□ Yes 2\(\overline{\pi}\)No
	3s or 2	al Dire	106. Street end Number  891 Dorsey Hotel Road	de 10g. Citizen of What Country?  21536 USA
020	ges 1 and 2 should be filed within 72 hours efter death with the Maryland it of Health and Mentel Hygiene. If item 27 is merked other then "natural", or items 23a or 28a-f ehow or other traumstic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 Yes, Zyl No If Yes, Zyl No Year or Dates:	of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0020	C 2 30	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usuel Oc (Give kind of work de liffe. DO NOT use re Telephone R	one during most of working tired)
pu	be filed tel Hyg d other event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
ryla	hould Id Men merke mstic	ပ	Robert E. Gulley  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Str	Martha Brown reet and Number or Rural Route Number, City or Town, State, Zip Code)
	alth en 27 is i			Lane, Grantsville, MD 21536
Baltimore,	permit. Pages 1 and 2 should be filed within Deportment of Health and Mentel Hygiene. Important: If item 27 is marked other then any injury or other traumstic event, the Monce.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other)	place)
altin	mit. Pa sertme sortant / injury		4 Donation 5 Other (Specify) Bittinger Cemete  21. Signature of Funeral Service Licensee 22. Name and Ac	ry, May 6, 2005 Bittinger, MD  ddress of Facility Newman Funeral Homes, P.A.
ä	permi Depermi Impor	Ш	. // // 12-1	er St, PO Box 275, Grantsville, MD 21536
3.	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart ailure. List only one cause on each line.	dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset end Death
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. ASPIRATION Properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the prope	eumon 18 7 Leura
	sit sit	lner	bue to (or as a consequence v).	
,	execute n and ial-tren	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):	
x 68760,	es that the death certificete be executed igned by the ettending physician and be deteched for use as the bunal-trensit	edical	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
Box	eath c ettend f for us	clan	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I. 23b. Did tobacco use contribute to the cause of death?
s, P.O.	requires that the death cert seen signed by the ettendin, hould be deteched for use	by Physician/W	Diskets Mellitus  Senile DEMENTIS	1 Yes 2 7 No 3 Probably 4 Unknown
Division of Vital Records,	requir been s should	Completed	Senile DEMENTIA	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
a B	The ate h page			1 ☐ Yes 2 ☐ Mo 1 ☐ Yes 2 ☐ No
<u>Ş</u>	Physicien: The this certificate and director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	26. Place of Death (Check only one)  Other: 4 □ Vursing Home 5 □ Residence 6 □ Other (Specify)
ion of	To the Hospital or Attending Phys within 24 hours effer death.  To the Funerel Director: After this completely filled in by the funeral di	ation: T	27. Manner of Death  1 DNatural 5 Pending (Month, Day Year)  28b. Time of Injury 28b. Time of Injury	Injury et Work?  28d. Describe how injury occurred  28d. Describe how injury occurred
Divis	I or Atte	ertific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)	ice 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	n 24 hour n 24 hour Ne Funere	Medical Certification:	29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, death occurred at the control of the basis of examination and/or investigation, in mand manner stated.	ne time, date and place, and due to the cause(s) and manner as stated.  my opinion, death occurred at the time, date and place, and due to the cause(s)
	Vithii To the	Σ		cense number 29d. Date signed (Month, Day, Year)
			Do Name and address of a season who completed across of death (hom 230) (Time Print)	25 6 58 MAY 4, 260-5
			30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)  SATURNINA CHANZIMD 1076/ New Hear	25638 MAY 4, 2005 rgs Creek Sw FROSTBURG Muryland 21532
	Sta Regist		31. Date filed (Month, Day, Year)  32. Retistrar's Signature	,

			For State Ragistrar	State of Marylan		artment of F		Mental Hy	giene O	05	16997
	Physici	an	Decedent's Name (First, Middle, La:     Marian	Wilki				2. Date of De		Year	3. Time of Death
<u> </u>	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, gives SACTED LEFE 5. Social Security Number 6. S	e street and number) RH MOSDIH	aL.	Cumi	R Location of Dea	8. Date of Bir	AH	ty of Death  CAI  9. Birthpl Coyn West	,
	D	ctor	Usual Residence of Decedent  10a. State 10b. County  W. Mineral		y, Town or L Keyser	ocation					0d. Inside City Limits 1 XX es 2 □ No
	ath with the Marylan 23a or 28a-f show ust be rediffed at	Funeral Director	10e. Street and Number 500 Carskadon	Lane		10f. Zip Code 2672			10g. Citizen o United	State	S
		۾	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 XNo If Yes, Give Year or Dates:	.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Specify Yes or No rto Rican, etc.)	Spec	ace - America ack, White, e afy: Whi	etc.
0-61717	within than	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	fucation ide completed) College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired Homemaker	during most of wo d)	orking	16b. Kind of	Business/Ind	lustry
/land	d be ental ked c	To Be C	17. Father's Name (First, Middle, Last) Frederick	Byer				me (First, Middle SSICA S	, Maiden Suma Shilling		
, Mar,	s 1 and 2 shoul f Health and M item 27 is marl other traumati		19a. Informant's Name/Relationship ( Jemma Dawson/ dau	ghter	152	ing Address (Street Mozelle S		er, West	Virgir	nia 26	726
aitimore	permit. Pages 1 Department of Hi Important: if iter any injury or ott pnce.		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licer	Removal from State St.	Pete:	osition (Name of smatory or other place is Cemete 2. Name and Addre				port	wn, State Maryland
n D	Departing any i		7 Wayse  23a. Part1. Enter the disease, or com	Soul		111 Churc	h St., W		ort, Mai		21562 Approximate
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Smll cell of Due to (or as a conseq	uence of	nortited a					Interval Between Onset and Death
,09/8/	certificate be executed rding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
O. BOX 6	death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	□Ectopic pregnancy	у			ate of delive	ry Day Year
ras, r.	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco use co		e cause of death? ably 4 Unknown
Kec	The law ate has b page 2 s	Completed						24a. Was auto perfe 1 Yes			osy findings available inpletion of cause of 2 No
sion of Vital	ling Phys n. After this funeral di	ation: To Be	25. Was case referred to medical examiner?  1  Yes  No  27. Manner of Death  Matural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Injur	ner: 4 🗆 Nursing		idence 6 0	urred	
DIVISION	in Sir Se	Certification:	3 Suicide 6 Could not b	e 28e. Place of Injury - At he building, etc. (Specif		treet, factory, office			(Street and Nun wn, State)	nber or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral i completely filled	Medical	(Check only 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, dea tion and/or in	th occurred at the timestigation, in my o	opinion, death occ	e, and due to the urred at the time,	cause(s) and r date and place 29d. Date sign	and due to	the cause(s)
	To Too		> two	Lotton		De		6	5/5/	105	/;
			30. Name and address of person who Steven R	Smith MO	100 Se	An Or C	ambertan	l mo			

Registrar

			1 - For State Registrar	State of Maryla	•	artment o		and Ment		ene 2005	16998
	Division		1. Decedent's Name (First, Middle, Last,						ate of Death	Day Yeer	3. Time of Death
	Physici /Medic		Virginia Jan	e Wilson				Ma	ay 09,	2005	1330 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	m, or Location o	of Death		4c. County of Deatl	1
			Greater Baltimore			Towson				Baltimore	1
	Funeral		5. Sociał Security Number 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. Security 1 6. S	7. Age (In y.	rs. last birthday) Yrs.	If Under 1 Ye Months Da		Min. 8. D.	late of Birth Mo <i>nth, Day</i> 1	9. Birth	nplace (State or Foreign untry) Yland
6	Director		Usual Residence of Decedent	0.5	110.			Ma	гу ч, т	942 Mai	yrand
	land ow		10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
	Mary Feb	ţō	MD Baltimo	re V	White F	Hall					1 ☐ Yes 2√∑ No
-	r 28g	Director	10e. Street and Number			10f. Zip Coo	de		10g	. Citizen of What Co	untry?
	th with	aD	19738 Grayston	e Rd.		211	61		1	J.S.A.	
	dea	Funeral		12. Was Decedent Ever in	U.S. 13.	Was Decedent	of Hispanic Orig Cuban, Mexican	gin? (Specify )	Yes or No-	14. Race - Amer Black, White	
9	or lt	J.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give		1 ☐ Yes 2 🛣		, , , , , , , , , , , , , , , , , , , ,	,,		hite
21215-0036	d within 72 hours after death with the Maryland Jiene. I then "natural", or lterna 23a or 28a-f ehow The Musical Ezama art must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:							
5	"nat	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Od kind of work do	ccupation one during most atired)	of working	16	b. Kind of Business/I	ndustry
12	within ene. than "	m.	Elementary/Secondary (0-12)	College (1-4or 5+)		nemakei				Own Hom	e
d 2	Hygi Other	e C	17. Father's Name (First, Middle, Last)					r's Name (Firs	st, Middle, Ma	iden Sumame)	
Maryland	should be and Mental marked o	To B	Calvin L. Wri	ght			Ele	enor (	Grace	Price	
ary	2 shou and M ie mar aumat	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Str	reet and Number	r or Rural Rou	ite Number, C	ity or Town, State, Z	ip Code)
	es 1 and 2 should be filed of Health and Mental Hyg I Item 27 ie marked othe r other traumatic event,		Harry T. Wilson	/Husband	197	38 Gra	aystone	e Rd.,	, Whit	e Hall,	MD 21161
ore.	of He of He filter		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F		p. Place of Dispo cemetery, crer			Date	20	c. Location - City or 1	
Ë	Pages nent of ant: if It ury or o		'4 □Donation 5 □Other (Specify)	M.	rest Lik ethodi	ertyU st Cem	nited   1	nay 13 2005	, M	hite Hal	ll, MD
Baltimore,	permit. Pages Department of Important: If I any Injury or once		21. Signature of Fureral Salvice Liouv	X	A 22	z. Name and Ad	duress of Facility	<sup>y</sup> J.J. J	Harten	stein Mor edom, PA	tuary, Inc.
700	-		23a. Part Enter the disease, or compl shook, or heart failure. List only or	cations that caused the de							Approximate
	Observation .		Immediate Cause (Final	4	vosis						Interval Between Onset and Death
1	Physician /Medical		diseas or condition resulting in death)	Due to (or as a cons							
	Examiner										
	n ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):						*
V	ocuted nd transi	Examine	that initiated events resulting in death) Last								
30,	oe execian a	I Ex	resutting in death) cast	Due to (or as a cons	equence of):						
8760	death certificate be executed e attending physician and of for use as the bunal-transit	edical		1.							
9 X	death certifica attending ph	/Me	IF FEMALE:	3c. If yes, outcome of pred	nancy				**	23d. Date of deliv	
Вох	atten for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time o	etal death 3	Ectopic pregna				Month Month	Day Year
o.		ysi	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknown			,				
<u>α</u>	law requires that the as been signed by th 2 should be detache	by Pl	Part II. Other significent conditions cor	ntributing to death but not r	esulting in the u	nderlying cause	given in Part I.	2	23e. Did tobac	co use contribute to	the cause of death?
of Vital Records,	quire nn sig uld b								1 🗌 Yes	2 □ No 3 □ Pro	babiy 4 Qunknown
00	aw requir as been si 2 should	Completed						2	24a. Was an	24b. Were aut	opsy findings available
æ	9 4 9	шо						_	autopsy performed	d? death?	ompletion of cause of
ita		BeC	25. Was case referred to medical				26. Place	of Death (Che		<u> </u>	
<b>{</b>	Physician: this certific ral director,	ToE	examiner? 1 □ Yes 2 ② No	lospital: 1 Inpatient 2	☐ ER/Outpatien	nt 3 DOA	Other: 4 Nur	rsing Home	5 🗌 Residenc	e 6 Other (Spec	ify)
			27. Manner of Death 1 ②Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. l	njury at Work?	28d. D	Describe how	injury occurred	
Sio	Attending r death. ector: Afte by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				1 ☐ Yes 2 ☐ N				
Division	or At fter o lirec	Certification:	4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, str ocify)	eet, factory, offi	ice		ocation (Stree City or Town, S	et and Number or Rui State)	al Route Number,
_	Hospitei 14 hours a Funeral I	2	29a, Certifier 1 Certifying Phys	icien: To the best of my k	nowledge death	n occurred at th	e time date and	I place, and di	ue to the caus	e(s) and manner as	stated
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examinate)	ner: On the basis of exami and manner stated.	ination and/or in	vestigation, in m	ny opinion, deatl	h occurred at I	the time, date	and place, and due	to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier		^		ense number			Date signed (Month	*
•			Dunthia Sur	Tano in	)	1)	0051	347		5/10/0	) 5
	5		30. Name and address of person who co	10 40 67	101 N.	Print) (Viaria	es St.	Balt	imor	e Mg 21	204
	Sta	te	31. Date filed (Month, Day, Year) MAY 1 8 200	32 Registrar's Sig	nature						
4	Registr	ar	MAT T 8 500	5 Ellen	& Son	ALB.					

1 - For State Regist	- 10000	State of Maryland	d / Department of F Certificate of		al Hygien		16999
	's Name (First, Middle, Las	st)			te of Death		3. Time of Death
Physician LUCY	LOUISE	YANNIELLO	4h City Town o		AY 5,	2005 c. County of Death	4:30 PM
MILL Funeral 5. Social Se	ENNIUM HEA	LTH CARE	FT. W	ASHINGTON   If Under 24 Hrs.   8. Da   Hours   Min.   (M		PRINCE ( 9. Birthp	GEORGES  blace (State or Foreign  black , DC
Usual Resid	6-9113 lence of Decedent 10b. County		, Town or Location	I	7 T T T		Od. Inside City Limits
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D 72 D 10 D 10 D 10 D 10 D 10 D 10 D 10 D 1	15. Decedent's Ed (Specify only highest gra ry/Secondary (0-12)	ducation ide completed)  College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b.	Kind of Business/In	
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	luchel	X	RAYMOND LA PLAT	FUNERAL SI	2064		
Physician Immediate disease or resulting in	, or heart failure. List only Cause (Final condition	plications that caused the death one cause on each line. a MISALIO SC Due to (or as a consequ	LENOTIC G	ng, such as cardiac or resp HOLOVASCUL		SASE	Approximate Interval Batween Orbet and Death
Sequentiall if any, lead cause. End Cause (Dis that initiate resulting in	y list conditions, ing to immediate er Underlying ease or injury	b	ence of):				
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S e gine A Partit. Ottik	er significant conditions	contributing to death but not resu	Ilting in the underlying cause gr	ven in Part I. 2	3e. Did tobacco	use contribute to the	he cause of death?
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Mediting 2 (a) (a) (b) (b) (c) (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d	ture and title of confifier	and manner stated.	29c. Licens	se number	29d. D	ate signed (Month,	Day, Year)
	M		-6 D	18545	Rele	449,	2005
3 PName	UISONSKY	completed cause of death (Item	OU) LANE (	SWIST U	ALDONE	F, Idd.	20602
State 31. Date fil Registrar	MAY 1 8	2005 32. Refisitar's Signat	H Gode				

State of Maryland / Department of Health and Mental Hygiene

1- For Amend Item#17, per FH, G843, 5/20/07/16/20 to Plant Registrar

Read. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day :35)P) W **Physician** ARTHUR ANTHONY 2005 May 16. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 MM 2□ F 011-01-6452 90 Yrs. Director May 12, 1915 Massachusetts Usual Residence of Decedent tha Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore 1 X Yes 2 ☐ No Maryland N/A Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 3900 N. Charles St., Apt 1001 21218 USA or Itams 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 2 should ba filed within 72 hours after on and Mental Hygiene. Is markad other than "natural", or Itan 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 2 White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Textile Industry 5+ Consultant & Sales 12 George Anthony 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <del>Ceorge</del> Karminsky Esther Karzminsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or othar traun Estelle Mary Anthony (Wife) 3900 N. Charles St., Apt. 1001 Balto., Md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Dulaney Valley Mem Gdns 5/21/05 21. Signature of Funeral Service Licensee Kevin E 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A Ecker 130 E. Fort Ave., Balto., Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischamic cardiony upsthe YEAV 5 Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) the a of Vital Records, P.O. be detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate has autopsy performed? Yes 20 No 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? Certification: After t (WHOOG) Natural 5 Pending investigation death. 2 □ No 1 Yes Hospital or Attendi 24 hours after death Funeral Director: A 2 🗋 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 2 2001 and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles Street VOON MMIS Towson, MD 21204 31. Date filed (Month Pa 32/Registrar's Signature State green s Registrar